CABINET FOR HEALTH AND FAMILY SERVICES

Office of Health Policy

(Amended After Comments)

900 KAR 5:020. State Health Plan for facilities and services.

RELATES TO: KRS 216B.010-216B.130

STATUTORY AUTHORITY: KRS 194A.030, 194A.050(1), 216B.010, 216B.015(28), 216B.040(2)(a)2.a.

NECESSITY, FUNCTION, AND CONFORMITY: KRS 216B.040(2)(a)2.a requires the cabinet to promulgate an administrative regulation, updated annually, to establish the State Health Plan. The State Health Plan is a critical element of the certificate of need process for which the cabinet is given responsibility in KRS Chapter 216B. This administrative regulation establishes the State Health Plan for facilities and services.

Section 1. The 2017-2019[~~Update to the 2015-2017~~] State Health Plan shall be used to:

(1) Review a certificate of need application pursuant to KRS 216B.040; and

(2) Determine whether a substantial change to a health service has occurred pursuant to KRS 216B.015(29)(a) and 216B.061(1)(d).

Section 2. Incorporation by Reference. (1) The "2017-2019[~~Update to the 2015-2017~~] State Health Plan", **October[~~July~~]**[~~January~~] 2017, is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Office of Health Policy, 275 East Main Street, 4WE, Frankfort,

Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.

900 KAR 5:020

_____

Paul A. Coomes Date
Executive Director
Office of Health Policy

APPROVED:

_____

Vickie Yates Brown Glisson Date
Secretary

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation: 900 KAR 5:020
Contact Persons: Molly Lewis, 502-564-7905, molly.lewis@ky.gov.; or Laura Begin, (502) 564-6746, laura.begin@ky.gov.

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation incorporates by reference the 2017-2019 State Health Plan, which shall be used to determine whether applications for certificates of need are consistent with plans as required by KRS 216B.040(2)(a)2.a.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to comply with the content of the authorizing statutes, specifically KRS 194A.030, 194A.050(1), 216B.010, 216B.015(28), and 216B.040(2)(a)2.a.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by incorporating by reference the 2017-2019 State Health Plan, which shall be used to determine whether applications for certificates of need are consistent with plans as required by KRS 216B.040(2)(a)2.a. KRS 216B.015(28) requires that the State Health Plan be prepared triennially and updated annually.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: The State Health Plan shall be used to determine whether applications for certificates of need are consistent with plans as required by KRS 216B.040(2)(a)2.a.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: The amendment incorporates by reference the 2017-2019 State Health Plan. Substantive changes include deletion of the common review criteria; revisions to the special care neonatal beds criteria to allow conversions between Level II and Level III NICU beds and to allow a hospital with 800 births to establish a Level II program; nursing facility criteria were revised to allow transfer/relocation of nursing facility beds within the same county, to a contiguous county, or to a county within the ADD, to delete the criterion regarding alleviation of an emergency circumstance, to allow for the establishment of nursing home beds for the provision of post-acute rehabilitation services, and to delete the requirement for a facility proposing to transfer beds to participate in the Cabinet's National Background Check Programs; home health agency review criteria were revised to delete the exemption criterion for accountable care organizations (ACOs) and to delete the requirement for Home Health applicants to participate in the Cabinet's National Background Check Program; cardiac catheterization review criteria were revised to delete the criteria regarding the cardiac catheterization pilot program for therapeutic catheterization programs without open heart surgery backup, and to establish review criteria for therapeutic catheterization programs to project 200 annual procedures and 50 procedures per interventional cardiologist by the second year of operation; the private duty nursing service definition was revised and the requirement for the applicant to

participate in the Cabinet's National Background Check Program was deleted. The Amended After Comments version makes several changes. First, the edition date was changed from July to October. The review criteria for special care neonatal beds was changed to allow a hospital with 700, rather than 800, births to establish a Level II program. The review criteria for nursing facility beds was changed to specify that the calculation for "C", which is the average number of empty beds in the county of application and all Kentucky counties contiguous to the county of application, shall not include nursing facility beds approved pursuant to the Post-Acute Transitional Care Pilot Program; and to establish requirements for the Post-Acute Transitional Care Pilot Program. The review criteria for home health agencies was amended to change the criterion for an application by a licensed Kentucky acute care hospital or critical access hospital proposing to establish a home health service with a service area no larger than the county in which the hospital is located and contiguous counties. For those applications, the criterion will require the hospital to document, in the last twelve (12) months, the inability to obtain timely discharge for patients who reside in the county of the hospital or a contiguous county and who require home health services at the time of discharge, rather than documenting that the hospital is performing "no different than" or "better than" specified national benchmarks. Additionally, the provisions for private duty nursing were amended to define "private duty nursing agency" and "private duty nursing service", and to change references from "service" to "agency" as appropriate. Lastly, several nonsubstantive changes were made throughout the State Health Plan for grammatical correctness, to use the same forms of expression and numbering format throughout the Plan, to correct typographical errors, and to comply with the drafting requirements of KRS Chapter 13A.

(b) The necessity of the amendment to this administrative regulation: The amendment is necessary to update the State Health Plan, which is used to determine whether certificate of need applications are consistent with the State Health Plan. Additionally, the Amended After Comments changes were necessary to respond to comments received during the public comment period.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by incorporating by reference the 2017-2019 State Health Plan.

(d) How the amendment will assist in the effective administration of the statutes: The amendment will provide the 2017-2019 State Health Plan, which will be used to determine whether certificate of need applications are consistent with the State Health Plan.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: This administrative regulation affects certificate of need applicants and affected parties requesting hearings. Annually, approximately 115 certificate of need applications are filed.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will

have to take to comply with this administrative regulation or amendment: Entities that submit certificate of need applications will be subject to the criteria set forth in the 2017-2019 State Health Plan.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): There will be no cost to entities to comply with this amendment.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Entities that submit certificate of need applications will be subject to the revised criteria set forth in the 2017-2019 State Health Plan.

(5) Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:

(a) Initially: No additional costs will be incurred to implement this administrative regulation.

(b) On a continuing basis: No additional costs will be incurred.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: No new funding will be needed to implement the provision of the amended regulation.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No fee or funding increase is necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: The administrative regulation does not establish or increase fees.

(9) TIERING: Is tiering applied? Yes, tiering is used as there are different CON review criteria for each licensure category addressed in the State Health Plan.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation: 900 KAR 5:020
Contact Persons: Molly Lewis, 502-564-7905, molly.lewis@ky.gov.; or Laura Begin, (502) 564-6746, laura.begin@ky.gov.

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? This administrative regulation impacts the Cabinet for Health and Family Services, Office of Health Policy and may impact any government owned or controlled health care facilities.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.030, 194A.050(1), 216B.010, 216B.015(28), and 216B.040(2)(a)2.a

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? This administrative regulation will not generate revenue for state or local government.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? This administrative regulation will not generate revenue for state or local government.

(c) How much will it cost to administer this program for the first year? No additional costs will be incurred to implement this administrative regulation.

(d) How much will it cost to administer this program for subsequent years? No additional costs will be incurred to implement this administrative regulation on a continuing basis.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):
Expenditures (+/-):
Other Explanation:

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
Office of Health Policy

900 KAR 5:020. State Health Plan for facilities and health services.

SUMMARY OF MATERIAL INCORPORATED BY REFERENCE

The 2017-2019 State Health Plan, October 2017, is incorporated by reference. The 2017-2019 State Health Plan shall be used to determine whether applications for certificate of need are consistent with plans as required by KRS 216B.040(2)(a)2.a.

Changes from the July 2017 edition to the October 2017 edition include the changes described in this summary.

- The edition date was changed from July to October.
- The review criteria for special care neonatal beds was changed to allow a hospital with 700, rather than 800, births to establish a Level II program.
- The review criteria for nursing facility beds was changed to:
    - Specify that the calculation for "C", which is the average number of empty beds in the county of application and all Kentucky counties contiguous to the county of application, shall not include nursing facility beds approved pursuant to the Post-Acute Transitional Care Pilot Program; and
    - Establish requirements for the Post-Acute Transitional Care Pilot Program.
- The review criteria for home health agencies was amended to change the criterion for an application by a licensed Kentucky acute care hospital or critical access hospital proposing to establish a home health service with a service area no larger than the county in which the hospital is located and contiguous counties. For those applications, the criterion will require the hospital to document, in the last twelve (12) months, the inability to obtain timely discharge for patients who reside in the county of the hospital or a contiguous county and who require home health services at the time of discharge, rather than documenting that the hospital is performing "no different than" or "better than" specified national benchmarks.
- The provisions for private duty nursing were amended to define "private duty nursing agency" and "private duty nursing service", and to change references from "service" to "agency" as appropriate.
- Lastly, several nonsubstantive changes were made throughout the State Health Plan for grammatical correctness, to use the same forms of expression and numbering format throughout the Plan, to correct typographical errors, and to comply with the drafting requirements of KRS Chapter 13A.

Total Number of Pages – 63

The total number of pages incorporated by reference in this administrative regulation is 63.

STATEMENT OF CONSIDERATION RELATING TO
900 KAR 5:020

CABINET FOR HEALTH AND FAMILY SERVICES
Office of Health Policy

Amended After Comments

I. A public hearing on 900 KAR 5:020 was held on August 21, 2017, at 9:00 a.m. in the Health Services Building, 275 East Main Street, Frankfort, Kentucky. Additionally, written comments were received during the public comment period.

II. The following people submitted comments during the public hearing and public comment period:

Name and Title	**Agency/Organization/Entity/Other**
Erin Moore	(No affiliation or contact info given)
Gerald Howard	(No affiliation or contact info given)
Johnni Green	(No affiliation or contact info given)
Mike Prin	(No affiliation or contact info given)
Scott Helton	(No affiliation or contact info given)
Tammy Gays	(No affiliation or contact info given)
Terry L. Watson	(No affiliation or contact info given)
Valerie Patrick	(No affiliation or contact info given)
Julia Crigler, KY State Director	Americans for Prosperity
Taylor Alford	Auburn, KY
Patricia T. Mason, Chief Strategy and Marketing Officer	Baptist Health, Louisville, KY
Dr. Robert H. Long, President/CEO	Baptist Life Communities, Erlanger, KY
Charles Lovell, Jr., Community Chief Executive Officer	Barbourville Appalachian Regional Healthcare, Barbourville, KY
Janna Shelley, Administrator	Barbourville Health & Rehabilitation Center, Barbourville, KY

Tommy Haggard, Chief Executive Officer	Bluegrass Community Hospital, Versailles, KY
Eli Grinspan, Executive Director	Bluegrass Health Partners, Richmond, KY
Teresa L. Kiskaden, Sr. Vice President of Operations	Bluegrass Health Partners, Richmond, KY
Matt Smith, MBA, CPPS, Chief Executive Officer	Bourbon Community Hospital, Paris, KY
Charlotte L. Roberts, Administrator	Bourbon Heights, Inc., Paris, KY
Amanda Purvis	Bowling Green, KY
Dorothy Key	Bowling Green, KY
Michael O. Buchanon, Warren County Judge Executive	Bowling Green, KY
Shelby Key	Bowling Green, KY
Walton Key	Bowling Green, KY
Amanda Woodcock	Brownsville, KY
Barbara Davis	Brownsville, KY
Becky Justis	Brownsville, KY
Brianna Whittinghill	Brownsville, KY
Brooklyn Bean	Brownsville, KY
Caitlan Poteet	Brownsville, KY
Cindi Whittinghill	Brownsville, KY
Cynthia Davis	Brownsville, KY
Darrell Basil	Brownsville, KY
Debbie Gibson	Brownsville, KY
Debbie Wells	Brownsville, KY
Garrett Mayse	Brownsville, KY
Helena Carroll	Brownsville, KY
Hunter Bean	Brownsville, KY
Jeannie Basil	Brownsville, KY
Joel Davis	Brownsville, KY
Jordan Davis	Brownsville, KY
Jourdian Lamar	Brownsville, KY

Karen Clines	Brownsville, KY
Kendall Whittinghill	Brownsville, KY
Konner Whittinghill	Brownsville, KY
Kyndal Whittinghill	Brownsville, KY
Maxine Cheek	Brownsville, KY
Nathaniel Lamar	Brownsville, KY
Olivia Davis	Brownsville, KY
Shane Wells	Brownsville, KY
Theresa Lamar	Brownsville, KY
Tommy Gibson	Brownsville, KY
Brad Kennedy, PT, MBA, Interim CEO	Cardinal Hill Rehabilitation Hospital, Lexington, KY
John Muller, DPT, LNHA, Chief Operating Officer	Carespring Healthcare Management
Harry M. Hays, Chief Executive Officer	Carroll County Memorial Hospital, Carrollton, KY
Joe Brainard, RN, LNHA, Administrator	Carter Nursing and Rehabilitation Center, Grayson, KY
Ron Evans, Regional Vice President – Southwest	CHI Health at Home, Milford, OH
Leisha Maynard, President/CEO	Citizens Bank, Paintsville, KY
Joseph M. (Mike) Exton, Councilman and Vice-Chair	City of Pioneer Village, Bullitt Co. GOP, Pioneer Village, KY
Robert Parker, Chief Executive Officer	Clark Regional Medical Center, Winchester, KY
Marilyn Ingram, Center Executive Director	Countryside Center, Bardwell, KY
William Covington	Covington's Convalescent Center & Rehab, Hopkinsville, KY
Maribeth Shelton, Assistant Administrator	Cumberland Valley Manor, Burkesville, KY
Paul Shepard, Administrator	Cumberland Valley Manor, Burkesville, KY
Vickie Dyer, LNHA, Compliance Officer	Cumberland Valley Manor, Burkesville, KY
Rick Hendrickson, Administrator and City Councilman	Dawson Springs, KY
Nick Lamkin, SVP, Chief Risk Officer & Senior Counsel	Diversicare Healthcare Services, Inc, Brentwood, TN
Elizabeth Townsend, NHA, Administrator	Diversicare Management Services, Franklin, TN

Wanda Meade, NHA, Division President	Diversicare Management Services, Franklin, TN
Lindsay Frazier Adams, LNHA, Administrator	Diversicare of Fulton, Fulton, KY
Jason Gumm, Administrator	Diversicare of Glasgow, Glasgow, KY
Vicki Butler, Sr Administrator	Diversicare of Greenville, Greenville, KY
Tom Davis, BA, LNHA, Administrator	Diversicare of Nicholasville, Nicholasville, KY
Cindy Salyers, LNHA, Administrator	Diversicare/Boyd Nursing and Rehabilitation Center, Ashland, KY
Trella Wilson, Administrator	Diversicare/Clinton Place, Clinton, KY
Mark Witt, LNHA	Diversicare/The Highlands Health & Rehab, Louisville, KY
Sarah Willis	Diversicare/Wurtland Nursing and Rehabilitation Center, Greenup, KY
Michael Fielden, Administrator and Part Owner	Dover Manor, Inc., Georgetown, KY
Allen Gillum, CEO/Manager	East Kentucky Network, LLC, dba Appalachian Wireless, Ivel, KY
Afton Proffitt	Elizabethtown, KY
Braden Proffitt	Elizabethtown, KY
Gale Williams	Elizabethtown, KY
James N. Williams	Elizabethtown, KY
John D. Pawley	Elizabethtown, KY
John Melloan	Elizabethtown, KY
Joni Melloan	Elizabethtown, KY
Kelly Emerine	Elizabethtown, KY
Ina Glass, MSN, RN, NHA, NEA-BC, FCN, Administrator, and Vice President	Ephraim McDowell Ford Logan Hospital and Ephraim McDowell Health, Stanford, KY
Robert Flatt, Administrator	Essex Nursing and Rehabilitation Center, Louisville, KY
Brian Springate, RN, CPPS, Chief Executive Officer	Fleming County Hospital, Flemingsburg, KY
Melissa Brown	Fountain Run, KY
Alexis Poteet	Franklin, KY
Ali Poteet	Franklin, KY
Bailey Poteet	Franklin, KY

Brad Hale	Franklin, KY
Brady Murray	Franklin, KY
Brooke Sanders	Franklin, KY
David Moore	Franklin, KY
Hannah Robey	Franklin, KY
Jack N. Wade	Franklin, KY
Juli Wade	Franklin, KY
Missy Kinnaird	Franklin, KY
Nancy E. Uhls	Franklin, KY
Ricky Murray	Franklin, KY
Sierra Escue	Franklin, KY
Stephanie Cornwell	Franklin, KY
Teresa Murray	Franklin, KY
Thmarsha Thompson	Franklin, KY
Kevin Badger, CEO/Owner	Friendship Health and Rehab, Pewee Valley, KY
Stacie Darnold, Administrator	Gallatin Nursing and Rehab, Warsaw, KY
Steve Brown, Former Member of C.O.N. Board	Glasgow, KY
Ashwani K. Anand	Glendale, KY
Barbara Key	Glendale, KY
Brian Cardin	Glendale, KY
Doss	Glendale, KY
Glenn Petersen	Glendale, KY
Jeff Key	Glendale, KY
Jerry Doss	Glendale, KY
Joe Crum	Glendale, KY
Marlinta Comer	Glendale, KY
Mary Key	Glendale, KY
Nina Cardin	Glendale, KY
Patricia Cardin	Glendale, KY

Tiffany L. Hart	Glendale, KY
Joseph Gass, M.D., Chair of the Department of OB/GYN	Graves-Gilbert Clinic, Bowling Green, KY
Srividyalakshmi Seshadri, M.D., Vice President	Graves-Gilbert Clinic, Bowling Green, KY
Greg Wells, Owner	Green Acres Health Care, Mayfield, KY
Brittany Hawes, MDS Coordinator	Green Hill Rehabilitation and Care, Greensburg, KY
Cathy Froggett, Director of Social Services	Green Hill Rehabilitation and Care, Greensburg, KY
David G. Garst, Executive Director	Green Hill Rehabilitation and Care, Greensburg, KY
Faye Hawes, Director of Central Supply	Green Hill Rehabilitation and Care, Greensburg, KY
George Prebee, Director of Dietary Services	Green Hill Rehabilitation and Care, Greensburg, KY
Janet Milby, Assistant Director of Nursing	Green Hill Rehabilitation and Care, Greensburg, KY
Jessica Sharpe, Director of Clinical Education and Infection Control	Green Hill Rehabilitation and Care, Greensburg, KY
Laranda Pendelton, Assistant Director of Recreation Services	Green Hill Rehabilitation and Care, Greensburg, KY
Melissa DeSpain, Director of MDS Services	Green Hill Rehabilitation and Care, Greensburg, KY
Monica Warren, Direction of Recreation Services	Green Hill Rehabilitation and Care, Greensburg, KY
Jonathan McGuire, Administrator	Greenwood Nursing and Rehabilitation Center, Bowling Green, KY
Darrell Hicks	Hargis and Associates LLC, Louisville, KY
Gail Hensley, Administrator	Harlan Health & Rehabilitation Center, Harlan, KY
Charlotte C. Thornsberry, RN, MSN, Administrator	Hazard Health and Rehabilitation Center, Hazard, KY
Jay H. Trumbo, Chief Financial Officer	Health Systems of Kentucky, LLC, Louisville, KY
Jan Helson	Helson Development Corporation, Louisville, KY
Keith Hewitt, M.D.	Hewitt & Davis Partnership, Bowling Green, KY
Harold C. Warman, Jr., President and CEO	Highlands Health System, Prestonsburg, KY
Gail M. Gibbs, Administrator	Hillcrest Health & Rehabilitation Center, Corbin, KY

Danny Glick, Executive Vice President	Hillsdale Furniture, Louisville, KY
Helen Johnson, Executive Assistant	Hillsdale Furniture, Smithfield, KY
Melinda Burgard, Center Executive Director	Hillside Center, Madisonville, KY
Trevor Davis, Administrator	Homestead Post Acute, Lexington, KY
David Anderson, Chief Executive Officer	Jackson Purchase Medical Center, Mayfield, KY
Stephen D. Wolnitzek, Treasurer	Kenton Housing, Inc, Covington, KY, and Wolnitzek, Rowekamp & Demarcus, P.S.C., Covington, KY
Elizabeth “Betsy” Johnson, President	Kentucky Association of Health Care Facilities, Louisville, KY
Annette Gervais, Executive Director	Kentucky Home Care Association
Michael T. Rust, President	Kentucky Hospital Association, Louisville, KY
Sherri Craig, Division Vice President, Public Policy	KentuckyOne Health, Louisville, KY
Timothy A. Bess, Chief Executive Officer	Lake Cumberland Regional Hospital, Somerset, KY
Tammy York, Administrator	Lake Way Nursing and Rehabilitation Center, Benton, KY
Tevis Tuggle, MBA, RN, LNHA, Administrator	Landmark of Lancaster Rehabilitation and Nursing Center, Lancaster, KY
Timothy L. Veno, President	LeadingAge Kentucky, Louisville, KY
Jay Frances, Chief Executive Officer	Legacy Health Services, Inc, Hopkinsville, KY
Gatewood Robbins	Lexington, KY
Richard A. MacMillan, Senior Vice President and Senior Counsel	LHC Group, Legislative and Regulatory Affairs, Lafayette, LA
Kerry K. Howard, General Manager/CEO	Licking Valley RECC
Tiffany Mayse	Lindseyville, KY
Stock Longhurst, Administrator	Louisville East Post Acute, Louisville, KY
Bryan W. Cole	Louisville, KY
Deborah Walker	Louisville, KY
DeVon March	Louisville, KY
Mark J. Harvey	Louisville, KY
Timothy D. Helson	Louisville, KY
Michael J. Yungmann, CEO and Senior Vice	Lourdes Hospital and Mercy Health,

President	Paducah, KY
James M. Shepherd, DMD, Public Health Director and Mayor	Magoffin County Health Department and City of Salyersville, Salyersville, KY
Mark Fritz, President	Mainstreet Health operations for Arizona and Texas
Darryl Wellinghoff, Executive Vice President	Mainstreet Health, Carmel, IN
Charlie McStoots	Mammoth Cave, KY
Savannah McStoots	Mammoth Cave, KY
Sierra McStoots	Mammoth Cave, KY
Susan Arnold	Management Advisors, Hazard, KY
Alecia Stephens, Biller	Management Advisors, Inc.
Beth Arnett, Administrator	Martin County Health Care Facility, Inez, KY
Conjuna Collier	Masonic Home of Shelbyville, Shelbyville, KY
Gary R. Marsh, President and CEO	Masonic Homes of Kentucky, Masonic Home, KY
Duran Hall, President/CEO	Maverick Insurance Group, LLC, Louisville, KY
Cortney Burkhart, RN, BSN, LNHA	Maysville Nursing and Rehabilitation Facility, Maysville, KY
Sally Baxter, BSN, RN, LNHA	Maysville, KY
Wade R. Stone, Executive Vice President	Med Center Health, Bowling Green, KY
Amy Neighbors, Administrator	Metcalfe Health Care Center, Edmonton, KY
Candie Bennett, Business Office Manager	Metcalfe Health Care Center, Edmonton, KY
Carolyn Adwell, RN, MDS Coordinator	Metcalfe Health Care Center, Edmonton, KY
Cassandra Brown, RN, Staff Development Coordinator	Metcalfe Health Care Center, Edmonton, KY
Cindy London, Medical Records Clerk	Metcalfe Health Care Center, Edmonton, KY
Claire Wilson, Administrative Assistant	Metcalfe Health Care Center, Edmonton, KY
Cody Brooks, Receptionist/LTC Intern	Metcalfe Health Care Center, Edmonton, KY
Donna Harris, Dietary Manager	Metcalfe Health Care Center, Edmonton, KY

Eris Smith, RN, Assistant Director of Nursing	Metcalfe Health Care Center, Edmonton, KY
Jackie Parker, Director of Nursing	Metcalfe Health Care Center, Edmonton, KY
Jimmy Smith, PTA, Rehab Director	Metcalfe Health Care Center, Edmonton, KY
Kandis Gallagher, Admissions/Social Services	Metcalfe Health Care Center, Edmonton, KY
Kristy Ford, LPN, Admissions Nurse	Metcalfe Health Care Center, Edmonton, KY
Linda Crenshaw, Environmental Services Director	Metcalfe Health Care Center, Edmonton, KY
Rochelle Jones, LPN, MDS Nurse	Metcalfe Health Care Center, Edmonton, KY
Sarah Fields, Accounts Payable/Payroll Clerk	Metcalfe Health Care Center, Edmonton, KY
Shelia McCoy, Activities Director	Metcalfe Health Care Center, Edmonton, KY
Michael Slusher, Community Chief Executive Officer	Middlesboro Appalachian Regional Healthcare, Middlesboro, KY
Christal Woody, RN	Middlesboro Nursing & Rehabilitation Facility, Middlesboro, KY
Christy Bean, Activities Director	Middlesboro Nursing & Rehabilitation Facility, Middlesboro, KY
Elaine Davis, RN	Middlesboro Nursing & Rehabilitation Facility, Middlesboro, KY
Gail Wilder, RN	Middlesboro Nursing & Rehabilitation Facility, Middlesboro, KY
Jeff Mayes, Maintenance Director	Middlesboro Nursing & Rehabilitation Facility, Middlesboro, KY
Jessica Brock, Medical Records Director	Middlesboro Nursing & Rehabilitation Facility, Middlesboro, KY
Jimmie Carol Prater, Director of Nursing	Middlesboro Nursing & Rehabilitation Facility, Middlesboro, KY
Linda Goodman, Housekeeping/Laundry Supervisor	Middlesboro Nursing & Rehabilitation Facility, Middlesboro, KY
Mary Whitaker, Human Resource Manager	Middlesboro Nursing & Rehabilitation Facility, Middlesboro, KY
Meagan Reynolds, RN	Middlesboro Nursing & Rehabilitation Facility, Middlesboro, KY
Megan Lamont, Social Services Director	Middlesboro Nursing & Rehabilitation Facility, Middlesboro, KY
Melissa Robbins, Administrator	Middlesboro Nursing & Rehabilitation Facility, Middlesboro, KY
Monica Johnson, Dietary Manager	Middlesboro Nursing & Rehabilitation Facility, Middlesboro, KY

Nancy Corkran, LPN	Middlesboro Nursing & Rehabilitation Facility, Middlesboro, KY
Sheri Craycraft, Bookkeeper	Middlesboro Nursing & Rehabilitation Facility, Middlesboro, KY
Sheron Smith, Payroll/Benefits Manager	Middlesboro Nursing & Rehabilitation Facility, Middlesboro, KY
Teresa Stout, RN	Middlesboro Nursing & Rehabilitation Facility, Middlesboro, KY
Brittany Whittinghill	Morgantown, KY
Kyle Whittinghill	Morgantown, KY
Franklin D. Fitzpatrick	Mountain Manor of Paintsville
Vivian Lambert, Administrator	Mountain View Nursing and Rehabilitation Center, Pineville, KY
Jessie Key	Nashville, TN
Bruce K. Duncan, Assistant Vice President	National HealthCare Corporation, Murfreesboro, TN
Mary N. Haynes, RN, MS, MSN, President	Nazareth Home, Louisville, KY
Angela White, Admissions Coordinator	Oakmont Manor, Flatwoods, KY
Angie Boremons	Oakmont Manor, Flatwoods, KY
Angie Smallwood	Oakmont Manor, Flatwoods, KY
Ashley Moore, RN	Oakmont Manor, Flatwoods, KY
Brittany Smith, LPN	Oakmont Manor, Flatwoods, KY
Bryan Sanders	Oakmont Manor, Flatwoods, KY
Cammy Thomas	Oakmont Manor, Flatwoods, KY
Carly	Oakmont Manor, Flatwoods, KY
Chelsie Seagraves, CMT	Oakmont Manor, Flatwoods, KY
Christy L. Viars	Oakmont Manor, Flatwoods, KY
Crystal Delong, RN BSN-BC, Director of Nursing	Oakmont Manor, Flatwoods, KY
George Thomas	Oakmont Manor, Flatwoods, KY
Gina McDaniels, Activity Assistant	Oakmont Manor, Flatwoods, KY
Jessica William, Dietary Manager	Oakmont Manor, Flatwoods, KY
Joann Smith	Oakmont Manor, Flatwoods, KY
Johnda Uriel	Oakmont Manor, Flatwoods, KY
K Bragg, LPN	Oakmont Manor, Flatwoods, KY

Karen Sturm	Oakmont Manor, Flatwoods, KY
Kathy Thomas, Activity Director	Oakmont Manor, Flatwoods, KY
Kayla Necola	Oakmont Manor, Flatwoods, KY
Kelly R. Clare, SRNA	Oakmont Manor, Flatwoods, KY
Kim Baldegh	Oakmont Manor, Flatwoods, KY
Kristina Poole, Administrative Assistant	Oakmont Manor, Flatwoods, KY
Lisa Butem, Dietary Cook	Oakmont Manor, Flatwoods, KY
Lonnie Brewer, Medical Records Director	Oakmont Manor, Flatwoods, KY
Pam Robinson, Nurse	Oakmont Manor, Flatwoods, KY
Peggy Hamilton, Housekeeping	Oakmont Manor, Flatwoods, KY
Randall Nimblett, Dietary Aide	Oakmont Manor, Flatwoods, KY
Rita Lewis, LPN	Oakmont Manor, Flatwoods, KY
S. Simmen, LPN	Oakmont Manor, Flatwoods, KY
Shanna Carver, Administrator	Oakmont Manor, Flatwoods, KY
Stacie Burton, LPN	Oakmont Manor, Flatwoods, KY
Stephanie Delong, LPN	Oakmont Manor, Flatwoods, KY
Steven D. Patterson, Activity Assistant	Oakmont Manor, Flatwoods, KY
Tracey Cotton, Quality Assurance Director	Oakmont Manor, Flatwoods, KY
Whitney Spears	Oakmont Manor, Flatwoods, KY
Kevin Halter, Chief Executive Officer	Our Lady of Bellefonte Hospital, Russell, KY and Bon Secours Kentucky Health System, Ashland, KY
Jeffrey Baxley, Center Executive Director	Owensboro Center, Owensboro, KY
Russ Ranallo, Vice President, Financial Services	Owensboro Health, Owensboro, KY
Angela Goff, Social Services Director	Parkview Nursing and Rehab, Pikeville, KY
Connie Wyatt, Medical Records Coordinator	Parkview Nursing and Rehab, Pikeville, KY
Linda Stidham, RN, Director of Clinical Services	Parkview Nursing and Rehab, Pikeville, KY
Lori Moberly, RN, Executive Director	Parkview Nursing and Rehabilitation Center/Life care Centers of America, Paducah, KY

Jesse Rudd II, PharmD	Parkway Pharmacy
Missy Bentley, RN, LNHA, Regulatory Liaison	PCPMG Consulting, LLC, Garrison, KY
Joshua H. Crawford, Co-Executive Director	Pegasus Institute
Mark Millet, MHA, NHA, Administrator	Pine Meadows Post-Acute, Lexington, KY
Donna D. Davis, Administrator	Princeton Health & Rehab Center Princeton, KY
Laura B. Alms, Esq.	Professional Case Management, Denver, CO
Brian W. Lebanion, Secretary	Professional Home Health Care Agency, Inc., London, KY
Heidi Schissler Lanham, Legal Director	Protection & Advocacy, Frankfort, KY
Jeff Key, Vice-President of Business Development	Rapid Recovery Centers, Mainstreet Health, Carmel, IN
Carla Benson, RN, ADON	Redbanks Colonial Terrace, Sebree, KY
Charlotte Armstrong, AP/Payroll Coordinator	Redbanks Colonial Terrace, Sebree, KY
Cheryl Forber, LPN, Staff Development	Redbanks Colonial Terrace, Sebree, KY
Kendall Thomas, ICD-10, QAPI	Redbanks Colonial Terrace, Sebree, KY
Lisa Thompson, Medical Records	Redbanks Colonial Terrace, Sebree, KY
Susan Parker	Redbanks Colonial Terrace, Sebree, KY
Tammy Tompkins, SSD	Redbanks Colonial Terrace, Sebree, KY
Tiffany Waymon, Director of Food Services	Redbanks Colonial Terrace, Sebree, KY
Erin Brown, Board Member	Redbanks Colonial Terrace, Sebree, KY
Joann Kuhlenschmidt, Accounts Payable	Redbanks Skilled Nursing Center, Henderson, KY
Randella Robinson	Redbanks Skilled Nursing Center, Henderson, KY
Shari Newton, BSN, RN-C, LTCA, Executive Director	Redbanks Skilled Nursing Center, Henderson, KY
Susan Phipps, RN, WCC	Redbanks Skilled Nursing Center, Henderson, KY
Michael Bowlden, Administrator	Richwood Nursing and Rehab, LaGrange, KY
Angie Ratliff, Administrator	Ridgeway Nursing and Rehabilitation, Owingsville, KY

Cyndi Osborne	Rineyville, KY
Jackie Carlin, Administrator	Rivers Edge Nursing and Rehabilitation Center, Prospect, KY
Melissa J. Allen, Administrator/CEO	Riverview Health Care Center, Prestonsburg, KY
Deborah L. Smith, Administrative Assistant	Robbins Enterprises, Elizabethtown, KY
Keith Johnson, CFO	Robbins Enterprises, Elizabethtown, KY
Robert E. Robbins, M.D.	Robbins Enterprises, Elizabethtown, KY
Linda McConnell, RN, LNHA, Administrator	Robertson County Health Care Facility, Mt. Olivet, KY
Brad Stanford, Administrator	Rosedale Green/Emerald Trace, Elsmere, KY
Edward P. Fritz, R.N., Board of Directors	Rosedale Green/Emerald Trace, Elsmere, KY
Gene Weaver, Board of Directors	Rosedale Green/Emerald Trace, Elsmere, KY
James L. Titus, Ph.D., Board of Directors	Rosedale Green/Emerald Trace, Elsmere, KY
Kelly Simmons, DNP, RN, Board of Directors	Rosedale Green/Emerald Trace, Elsmere, KY
Londa Knollman, Executive Director/Administrator	Rosedale Green/Emerald Trace, Elsmere, KY
Mark Middendorf, M.D., Board of Directors Member	Rosedale Green/Emerald Trace, Elsmere, KY
Michael Hemm, Board of Directors	Rosedale Green/Emerald Trace, Elsmere, KY
N. Nick Ziegler, Board of Directors	Rosedale Green/Emerald Trace, Elsmere, KY
Carson Montgomery	Salyersville, KY
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Manuel Montgomery	Salyersville, KY
Mark Green	Salyersville, KY
Oscar Green, Jr.	Salyersville, KY
Pansy Blanton	Salyersville, KY
Regina Carty	Salyersville, KY
Sharon Blanton Howard	Salyersville, KY
Thelma J. Green	Salyersville, KY

Vickie Green	Salyersville, KY
Debra Finneran, RN, BSN, NHA, Sr. Vice President for Health Services	Sam Swope Care Center, Masonic Homes of Kentucky, Masonic Home, KY
Beth & Dave Gripp	Scottsville, KY
Catherine Grapes	Scottsville, KY
Cathy LaFitte	Scottsville, KY
Dr. Colin G. Fultz, D.C.	Scottsville, KY
Dr. Grant G. Watkins, D.C.	Scottsville, KY
Edwina Jordan	Scottsville, KY
Emily Towe	Scottsville, KY
Frank Vargo	Scottsville, KY
Josh Rickman	Scottsville, KY
Joyce Wheeler	Scottsville, KY
Katelynn Kiene	Scottsville, KY
Krista Shoulders	Scottsville, KY
Lois Jansen	Scottsville, KY
Michael Kiene	Scottsville, KY
Michelle Watkins	Scottsville, KY
Morgan Keen	Scottsville, KY
Nancy & Bill Wooldridge	Scottsville, KY
Nancy Campise	Scottsville, KY
Pat Pfeiffer	Scottsville, KY
Shanda M. Graves	Scottsville, KY
Sydney Hurt	Scottsville, KY
Teresa Vargo	Scottsville, KY
Terri Anderson	Scottsville, KY
Tina Vargo	Scottsville, KY
Troy Anderson	Scottsville, KY
Tyna McDonald	Scottsville, KY
Valerie Vargo	Scottsville, KY

Kathy E. Gallin, Director of Legislative Affairs	Signature HealthCARE Consulting Services, LLC, Louisville, KY
Stephanie Lindsey, CAN, LTCA, CEO	Signature HealthCARE of Bowling Green, Bowling Green, KY
Jeff Stidam, Director Special Projects/Administrator	Signature HealthCARE, LLC
Peggy King, Vice President of Branding and Communications	Signature HealthCARE, LLC, Louisville, KY
Dianne Timmering	Signature HealthCARE, Louisville, KY
George Burkley, Chief Strategy Officer	Signature HealthCARE, Louisville, KY
Sue Sanders	Smiths Grove, KY
Billie Hurst, Director of Human Resources	Somerset Nursing and Rehabilitation Facility, Somerset, KY
Jennifer Davis, BS, LNHA, Administrator	Somerset Nursing and Rehabilitation Facility, Somerset, KY
Jerree Humphrey, RN/Clinical Coordinator	Somerset Nursing and Rehabilitation Facility, Somerset, KY
Linda Rubarts, LPN MDS Coordinator	Somerset Nursing and Rehabilitation Facility, Somerset, KY
Vanessa Hines, Admissions and Marketing Coordinator	Somerset Nursing and Rehabilitation Facility, Somerset, KY
Brian K. Jaggers, LLTCA, CDP, Administrator	Somerwoods Nursing and Rehabilitation Center, Somerset, KY
Aaron Hart	Sonora, KY
Anita G. Hart	Sonora, KY
Stuart Locke, CRT, CPA, Chief Executive Officer	Southern Kentucky Rehabilitation Hospital, Bowling Green, KY
Sandra J. Dick, Administrator	Spring Creek Health Care, Murray, KY
Tim Trottier, Chief Executive Officer	Spring View Hospital, Lebanon, KY
Mark J. Neff, President/CEO	St. Clair Regional Medical Center, Morehead, KY
Garren Colvin, President and Chief Executive Officer	St. Elizabeth Healthcare
Janet A. Craig, Attorney	Stites & Harbison, Lexington, KY, on behalf of Pikeville Medical Center
Mark Sanders, PE, Vice President and Board Members	Summit Engineering, Inc., and One East Kentucky
Amy Hicks	Superior Care Home, Paducah, KY
Beth Harlacher, LPN, Staff Development Coordinator	Superior Care Home, Paducah, KY

Bruce Taffer, Director of Environmental Services	Superior Care Home, Paducah, KY
Carrie Armstrong	Superior Care Home, Paducah, KY
Darla Sims	Superior Care Home, Paducah, KY
Deann Metcalf, Social Events Director	Superior Care Home, Paducah, KY
Jennifer Myers, Administrator	Superior Care Home, Paducah, KY
Joni Culp, LPN, CDP	Superior Care Home, Paducah, KY
Kattie Wheeler	Superior Care Home, Paducah, KY
Mary Jo Sprouse, PT, Therapy Program Manager	Superior Care Home, Paducah, KY
Michelle Fellows, Human Resources	Superior Care Home, Paducah, KY
Mike Sims	Superior Care Home, Paducah, KY
Steven L. Hall, MPH, NHA, Assistant Administrator	Superior Care Home, Paducah, KY
Tana Cooper, RN, Assistant Director of Nursing	Superior Care Home, Paducah, KY
Tori Tiller, Business Office Manager	Superior Care Home, Paducah, KY
Cindy O'Banion, Administrator	The Grandview Nursing and Rehabilitation Facility, Campbellsville, KY
Donna Cawood	The Heritage Long Term Care and Rehabilitation Facility, Corbin, KY
Hattie Helton, LPN	The Heritage Long Term Care and Rehabilitation Facility, Corbin, KY
Kimberly Bray	The Heritage Long Term Care and Rehabilitation Facility, Corbin, KY
Lois Phipps, RN	The Heritage Long Term Care and Rehabilitation Facility, Corbin, KY
Jessica Broughton, RN, Director of Nursing	The Heritage Nursing and Rehab Facility, Corbin, KY
Shay Brown, AAS BSS, Director of Social Services and Deputy Registrar of Vital Statistics	The Klondike Center, Louisville, KY
Beverly Satterfield, Activities Director	The Terrace Nursing Facility, Berea, KY
Cassandra Thompson, Director of Environmental Services	The Terrace Nursing Facility, Berea, KY
Christina Saylor, Dietary Director	The Terrace Nursing Facility, Berea, KY
Health Payne, Maintenance Director	The Terrace Nursing Facility, Berea, KY

Kelly Belcher, Administrator

Kim Tincher, Director of Business Office

Rebecca Fernald, Director of Social Services

Tara Helton, Director of Nursing

Tina Harris, Staff Development/CQI Director

Bud Wethington, CEO

Chris Maddox, LPN, RACT-CT, Health Care Risk Manager
Lavinia O'Connor, Accounts Receivable Manager
Mike Wideman

Jeff Wilder, Administrator

Kathy Corbin, Director of Licensing

Randall J. Bufford, President and CEO

Alan Palmer, Board Chair

Paul Patton, Chancellor and Chair

Anita Lewis, Social Services Director

Joy Dingess, Administrator

Karen Lawson, LPN

Pam Hook, Business Office Manager

Shelby Richmond Riley, Health Information Management
Angie Hamer, RN, RAC-CT, Quality Assurance Nurse

Terry Skaggs, Chief Financial Officer and Chairman of the Board of Directors

Michelle Jarboe

Patricia J. Stansbury

The Terrace Nursing Facility, Berea, KY
The Terrace Nursing Facility, Berea, KY
The Terrace Nursing Facility, Berea, KY
The Terrace Nursing Facility, Berea, KY
The Terrace Nursing Facility, Berea, KY
TJ Regional Health, Inc., Glasgow, KY

Treyton Oak Towers, Louisville, KY

Treyton Oak Towers, Louisville, KY

Treyton Oak Towers, Louisville, KY

Tri-Cities Nursing and Rehabilitation Center, Cumberland, KY
Trilogy Health Services, LLC, Louisville, KY
Trilogy Health Services, LLC, Louisville, KY
TriStar Greenview Regional Hospital, Bowling Green, KY
University of Pikeville and One East Kentucky, Pikeville, KY
Vanceburg Rehab and Care, Vanceburg, KY
Vanceburg Rehab and Care, Vanceburg, KY
Vanceburg Rehab and Care, Vanceburg, KY
Vanceburg Rehab and Care, Vanceburg, KY
Vanceburg Rehab and Care, Vanceburg, KY
Wells Health Systems, Owensboro, KY
Wells Health Systems, Owensboro, KY, Kentucky Association of Health Care Facilities
Williamsburg Health and Rehab, Williamsburg, KY
Wimsatt Management Co., Inc., Louisville, KY

Robin Boren, Bookkeeper	Wimsatt Management Co., Inc., Louisville, KY
Mary Wimsatt Glick	Wimsatt Realty, Louisville, KY
Amelia Prater, Administrator	Wolfe County Health and Rehabilitation Center, Campton, KY
Kimberly B. Nall, Administrator	Woodland Oaks HCF, Ashland, KY
Jenifer Cornwell, Director of Social Services	Woodland Oaks Health Care Facility, Ashland, KY
Tiffany Bryan, Assistant Administrator	Woodland Oaks Health Care Facility, Ashland, KY
Donna Little, Regulatory Compliance Senior Policy Advisor	Cabinet for Health and Family Services

III. The following people from the promulgating administrative body responded to the comments received:

Name and Title	**Department**
Molly Lewis, Deputy General Counsel	Cabinet for Health and Family Services, Office of Legal Services
Donna Little, Regulatory Compliance Senior Policy Advisor	Cabinet for Health and Family Services

IV. SUMMARY OF COMMENTS AND RESPONSES

(1) Subject: General Support for Certificate of Need

(a) Comment: General comments in support of the Certificate of Need program were received from the Kentucky Hospital Association, Baptist Health, Lake Cumberland Regional Hospital, Kentucky Home Care Association, Our Lady of Bellefonte Hospital, Bon Secours Kentucky Health System, TJ Regional Health, Inc., and St. Clair Regional Medical Center. Those comments are included and summarized as part of this comment.

1. Michael T. Rust, Kentucky Hospital Association, Louisville, KY, commented that the Kentucky Hospital Association represents 127 member hospitals and commended the Cabinet's value in preserving and strengthening the certificate of need program and for proposing changes to improve on the ability of hospitals to provide high quality care through the continuum of care for the patients they serve. KHA and its members share in the goal to modernize the program to reflect both the growth in technology and emerging payment and delivery trends as well as to reduce regulatory barriers where possible. The KHA's comments are specific to components of the State Health Plan and reflect areas of strong consensus by the KHA member hospitals. These recommendations were developed by the KHA CON Committee and approved by the KHA Board of Trustees.

Mr. Rust submitted the following comments expressing the organization's position

on certificate of need and support of measures to preserve the certificate of need program: “The KHA and our member hospitals and systems strongly support having a robust Certificate of Need program as our collective desire is to assure access to quality health care services and to uphold the statutory intent of the Kentucky CON program – ‘to insure that the citizens of this Commonwealth will have safe, adequate, and efficient medical care; that the proliferation of unnecessary health-care facilities, health services, and major medical equipment results in costly duplication and underuse of such facilities, services, and equipment; and that such proliferation increases the cost of quality health care within the Commonwealth.’ While there have been marked changes in the health care delivery system in recent years, these principals still hold true today. CON provides an important stabilizing force in our health care access in this time of significant change.

“Kentucky’s CON program as currently constituted is not onerous in comparison to the other 36 states’ CON programs and allows considerable flexibility to providers to undertake needed projects. The additional improvements offered by the Cabinet for Health and Family Services further that goal. KHA commends the Cabinet for providing flexibility and modernization to allow providers to meet the changing needs of patients, and emerging payment models by both government and private payers. We support the proposed changes and request consideration of some additional revisions to the home health and PRTF Level II criteria to enable hospitals to meet the need of Medicaid patients and those with complex care needs for which there is a lack of access in many areas.

“KHA applauds the Cabinet for preserving the acute care bed need methodology and ambulatory surgery center criteria in light of the excess capacity for both inpatient care and outpatient surgery services demonstrated in Annual Utilization and Services Reports published by the Office of Health Policy. Additionally, we thank the Cabinet for preserving MRI under the formal review process in order to protect rural providers and better assure a standard level of quality services across provider types.”

2. Comment: Patricia T. Mason, Baptist Health, Louisville, KY, commented that Baptist Health represents eight (8) owned hospitals, one (1) managed hospital, and over 200 outpatient service locations across Kentucky. Baptist Health remains supportive of the Cabinet’s efforts to retain the Certificate of Need (CON) program and for recognizing the importance of modernizing the program to reflect current payment and delivery trends. The Cabinet’s efforts to reduce regulatory barriers to help Kentucky hospitals deliver needed services are appreciated.

3. Timothy A. Bess, Lake Cumberland Regional Hospital, Somerset, KY, commented in support of the “new CON standards in the new State Health Plan” and stated that “the hospital strongly supports having a robust Certificate of Need Program as our collective desire is to assure access to quality health care services and to uphold the statutory intent of the Kentucky CON program…”

4. Annette Gervais, Kentucky Home Care Association, Lexington, KY, commented that the KHCA is a trade association that has represented and served Kentucky’s home health and home care industry since 1974. KHCA represents approximately 70 home health agencies that are for profit, non-profit, health department based, multi-state as well as independent. KHCA also represents hospices, private duty nursing agencies, personal

services agencies, and companies that deliver durable medical equipment and supplies. KHCA is active on the national level with the National Association for Home Care and Hospice and the National Hospice and Palliative Care Organization.

Home health care, in all of its forms, is, and will continue to be, a lynch pin in the evolution of the health care delivery system. The home care industry must maintain its economic viability and stability. KHCA strongly supports the Certificate of Need ("CON") Program and the inclusion of review criteria in the State Health Plan for responsible and orderly growth. Because existing agencies can add patients in their current service areas, it is arguable that sufficient capacity to serve additional patients already exists.

Regarding private duty nursing services, KHCA appreciates and supports the revision to the definition of a "Private Duty Nursing Service." KHCA also supports the removal of the definition of pediatric patients in former Review Criterion 4. This revision is consistent with payor requirements, which define pediatric patients as those under age 22. The KHCA recommends that these proposed revisions remain intact.

5. Kevin Halter, Our Lady of Bellefonte Hospital, Russell, KY, and Bon Secours Kentucky Health System, Ashland, KY; and Bud Wethington, TJ Regional Health, Inc., Glasgow, KY; commented that his organization supports retaining a strong CON program in Kentucky and preserving regulatory measures that assure the program is managed and maintained as intended by the Kentucky General Assembly when the program was established. Given the rapid changes in health care delivery and payment that are taking place in the public and private sector, the CON program remains as important now as it was when it was established. It is a key stabilizing agent, assuring providers of care for indigent and Medicaid patients are able to continue providing a full range of needed healthcare services to vulnerable populations. Maintaining a strong certificate of need program that utilizes need-based criteria to determine when services should be established assures access to high quality patient care services and financial stability of existing providers, especially those serving Medicaid and underinsured populations regardless of their ability to pay.

Mr. Wethington also commented that TJ Regional Health applauds the Cabinet for preserving the acute care bed need methodology and ambulatory surgery center criteria in light of the excess capacity for both inpatient care and outpatient surgery services demonstrated in Annual Utilization and Services Reports published by the Office of Health Policy. Additionally, they thanked the Cabinet for preserving MRI under the formal review process in order to protect rural providers and ensure a standard level of quality services across provider types.

6. Mark J. Neff, St. Clair Regional Medical Center, Morehead, KY, stated that St. Clair Regional Medical Center strongly supports Kentucky's Certificate of Need process as they believe it provides both stability and sustainability for the state's hospitals. Further, they support the proposed changes filed by the Cabinet, including preservation of CON (including acute care bed need methodology and ambulatory surgery center criteria) and Neonatal Intensive Care Units (including for flexibility to expand NICU services to address the increased need for NICU beds to treat NAS and to assess adequate access of Level II services).

(b) Response: The Cabinet appreciates the comments in support of the Certificate of Need program. KRS 216B.010 establishes legislative findings and purposes, including authorizing "the Cabinet for Health and Family Services to perform any certificate-of-need function and other statutory functions necessary to improve the quality and increase access to health-care facilities, services, and providers, and to create a cost-efficient health-care delivery system for the citizens of the Commonwealth." Additionally, KRS 216B.040(2)(a)2.a. requires that plans approved by the cabinet be consistent with the state health plan and that the state health plan be updated annually.

(2) Subject: Acute Care Beds – Proposal to Add New Criterion Regarding Level I and II Trauma Centers

(a) Comment: Two comments were received regarding a proposed amendment to the review criteria for acute care beds for Level I and II trauma centers. An attorney representing Pikeville Medical Center, Inc. submitted a comment in support of this additional criterion, while the Highlands Health System submitted a comment in opposition to that additional criterion. Both comments are included and summarized as part of this comment.

1. Janet A. Craig with Stites & Harbison, PLLC, stated that she was commenting on behalf of Pikeville Medical Center, Inc. (PMC), which is a not-for-profit hospital located in Pike County, Kentucky. PMC has proposed adding a fourth criterion for acute care beds. The requested criterion would amend "I. Acute Care; B. Acute Care Beds; Review Criteria", and would read as follows:

> 4. Notwithstanding criteria 1., 2., and 3. above, an application by an existing licensed acute care hospital which is verified as a Level I or Level II Trauma Center and which has received written acknowledgement from the Cabinet for Health and Family Services, Office of Health Policy recognizing that an emergency exists with respect to acute care beds being applied for.

Ms. Craig's comments also stated:

> The addition of this criterion would allow the hospitals with Level I or Level II trauma centers that are experiencing an emergency circumstance with respect to the availability of acute care beds, as determined by the Cabinet for Health and Family Services, to have their CON applications for additional acute care beds reviewed and approved more easily, in an effort to alleviate the identified emergency. Such applicants would still have to satisfy the requirements in the CON emergency circumstances regulation (900 KAR 6:080)…
>
> Trauma center verification is done by The American College of Surgeons and the process includes verifying that a trauma center has the necessary resources for delivering optimal trauma care. The proposed addition to the State Health Plan is necessary for verified trauma centers operating in Kentucky that have licensed acute care beds that are full on an almost daily basis, which means that these hospitals cannot accept patients requiring urgent health care services without exceeding its number of authorized beds. If Kentucky's Level I and Level II trauma centers cannot provide care because they do not have bed availability, then, in

many cases, patients will not be able to receive the service in the service area and will have to be transferred. For many acute care services, including traumas, heart attacks, strokes, and infectious diseases, it is vital for patients to receive treatment as soon as possible and, most importantly, within the golden hour. Both mortality and morbidity increase with the transfers.

2. Harold C. Warman, Jr., Highlands Health System, Prestonsburg, KY, stated that his facility strongly opposes an amendment proposed by Pikeville Medical Center to adopt additional exception criteria for the addition of acute care beds that would apply only to Level I and II trauma centers. The current SHP review criteria governing the addition of acute care beds have been in effect for quite some time. The SHP includes target utilization rates for different facilities depending on the number of licensed acute care beds. There is also an exception that applies generally to all acute care hospitals if a hospital has reached "functional capacity". The existing review criteria allow an applicant to gain approval for additional beds based on a reasonable forecast of future utilization or a regression analysis of patient day trends over a five (5) year time frame. Many, many applications for additional acute care beds have been approved under this functional capacity exception. Further, the Cabinet has routinely relied on an applicant's reasonable forecast of future utilization or a regression analysis projection to determine the number of additional beds to be approved. There is simply no need for additional exception criteria for the addition of acute care beds.

Acute bed occupancy as reported in the Kentucky Annual Hospital Utilization and Services Reports shows that applications have been routinely approved even though the reported statewide occupancy has hovered just under fifty (50) percent for quite some time; in 2016, it was only 47.7 percent.

Finally, with or without any trauma center designation, every acute care hospital in Kentucky provides emergency medical services. Significantly, while emergency services are a valuable and necessary component of the healthcare system, they generate a financial loss. There is no reason to reward a provider with special privileges simply because they have sought an additional designation for services that all hospitals are obligated to provide. The healthcare system in Eastern Kentucky is already in a fragile state. To allow Pikeville to have free reign on the addition of acute care beds would only jeopardize this situation.

(b) Response: The Cabinet appreciates the comments regarding the proposal to add new criterion to the Review Criteria for Acute Care Beds regarding Level I and II trauma centers. The Cabinet will not amend the State Health Plan regarding this comment at this time. This proposal needs further consideration and review.

Currently, there are processes in place for additional acute care beds to be added to respond to an emergency circumstances. Those requirements are established in 900 KAR 6:080.

(3) Subject: Neonatal Care Beds

(a) Comment: Comments regarding the changes in the State Health Plan regarding Neonatal Care Beds were received from Kentucky Hospital Association, Baptist Health,

Graves-Gilbert Clinic, Hewitt & Davis, KentuckyOne Health, Owensboro Health, St. Elizabeth HealthCare, and Tri-Star Greenview Regional Hospital. Those comments are included and summarized as part of this comment. (This comment relates to "I. Acute Care; D. Special Care Neonatal Beds; Review Criteria".)

1. Michael T. Rust, Kentucky Hospital Association, submitted the following comments expressing the organization's position on certificate of need and comments expressing the organization's support of the Cabinet's proposal to amend the State Health Plan to provide flexibility to hospitals "treating complex neonatal patients, especially with the drastic increase of the diagnosis of neonatal abstinence syndrome (NAS) patients. Thank you for recognizing the need for flexibility to expand NICU services to address the increased need for NICU beds to treat NAS and to assess adequate access of Level II services in all regions of the state. KHA is seeking clarification on one proposed change within this section of the SHP. The Cabinet proposes to allow hospitals to convert Level II to Level III beds but does not appear to require the hospital maintain a minimum unit of Level II beds. KHA would like to clarify if it is the intent of the Cabinet to allow NICU Level III hospitals to have no licensed Level II beds."

2. Patricia T. Mason, Baptist Health, Louisville, KY, commented that Baptist Health supports the Cabinet's efforts to change criteria in the State Health Plan to enable more flexibility in meeting the needs of complex neonatal patients in Kentucky. Specifically, Baptist Health supports revisions that allow establishment of new Level II services and the ability to convert Level II beds to Level III beds. Having this flexibility is very important, as the challenges in caring for neonatal abstinence syndrome babies have continued to grow. Baptist Health is a major provider of obstetrical services in Kentucky and operates five (5) neonatal intensive care units, with sixty-seven (67) licensed neonatal beds. The Cabinet's recognition of the growing need for these types of services is appreciated.

3. Joseph Gass, M.D., Graves-Gilbert Clinic, Bowling Green, KY, commented that the Graves-Gilbert Clinic is a physician-owned multi-specialty group that has been caring for patients in Bowling Green and South Central Kentucky for eighty (80) years. During their eighty (80) years, they have seen different cost control programs come and go and have seen the State Health Plan change year to year. As a group, they support the proposed change regarding Special Care Natal Beds and any other changes that would either dissolve the current CON process or lighten its grip on innovation and competition. They strongly believe that innovation and competition will, on a long term basis, accomplish the goal of cost control.

The proposal calls for a threshold of 800 deliveries per year. They believe that this could safely be lowered to 700 without diminishing the program.

4. Srividyalakshmi Seshadri, M.D., Graves-Gilbert Clinic, Bowling Green, KY, commented that the Graves-Gilbert Clinic delivered 1,069 babies last year out of approximately 2,400 total delivered in the community. They embrace and support the Cabinet's proposed Neonatal Level II Criterion 10. Any hospital with the necessary staff and with 800 or more annual births can clearly support a Level II nursery. Having significantly more than 800 annual births in the community, the requirements to allow for

the development of a Level II nursery are without a doubt met. Their growing community benefits by offering multiple Level II nurseries.

With increases in babies born with neonatal abstinence syndrome ("NAS") and other medical conditions requiring more than a normal newborn nursery, the need for Level II providers continues to grow. NAS is an increasing problem in Kentucky. They greatly appreciate the Cabinet's recognition of this situation and the proposal to allow development of Level II nurseries in hospitals with at least 800 annual deliveries.

5. Keith Hewitt, M.D., Hewitt & Davis Partnership, Bowling Green, KY, commented that he supports the Neonatal Level II Criterion 10 proposed in the State Health Plan. He stated, "As a physician that has practiced for over 20 years, I have confidence that a hospital that can deliver 700 or more births can support a Level II nursery."

6. Sherri Craig, KentuckyOne Health, Louisville, KY, commented in support of the State Health Plan revision to review criteria addressing Level II Neonatal Services addressing "the pressing need for additional Level II NICU units in rural areas of Kentucky. One of those areas is London, Kentucky in which KentuckyOne Health operates Saint Joseph London Hospital. By enabling hospitals of this size, with the appropriate structure in place, mothers who deliver babies with Neonatal Abstinence Syndrome ("NAS") and other medical conditions will be able to receive care close to their homes. Enabling Saint Joseph London to provide Level II NICU should eliminate the necessity of transporting babies to the University of Kentucky's Children's Hospital in Lexington, more than 70 miles away. In 2016, approximately 90 babies were transported to UK, approximately 60 of whom were born with NAS which typically requires Level II NICU care. The transportation of these babies costs $4,000.00 to $6,000.00 per transport. According to the Public Health Neonatal Abstinence Syndrome Reporting Registry, Kentucky has one of the highest incidence rates for NAS in the United States. Within Kentucky, higher number of cases are reported in the Appalachian counties, which includes Laurel County. Approximately 80% of the NAS births in Kentucky are to mothers with other children and most are covered by Medicaid. Transportation of these babies creates further complications for families already in stressful situations. Mothers and families have difficulty traveling to the baby as well as finding places to stay, among other issues.

Further, Ms. Craig stated that KentuckyOne Health appreciates the Cabinet's recognition of the importance of providing Level II NICU services close to the mother's and baby's family. She referenced a New York Times article (attached to her comments) recognizing "the significance of maternal-child bonding in the rehabilitation of the mother and addressing the care needs of the baby." Ms. Craig stated that Saint Joseph London "looks forward to establishing a Level II NICU to meet the unfortunate growing need to treat babies with NAS in its service area."

7. Russ Ranallo, Owensboro Health, Owensboro, KY; commented that Owensboro Health supports the proposed change regarding NICU services and recognizing the need for flexibility to expand NICU services to address the changing needs of that patient population.

8. Garren Colvin, St. Elizabeth Healthcare, stated that St. Elizabeth specifically

appreciates the Cabinet's recognition of the increasing challenges to treating complex neonatal patients, especially with the drastic increase of the diagnosis of neonatal abstinence syndrome (NAS) patients. There is a flexibility to expand NICU services to address the increased need for NICU beds to treat NAS and to assess adequate access of Level II services in all regions of the state.

9. Alan Palmer, TriStar Greenview Regional Hospital, Bowling Green, KY, commented in support of the State Health Plan revision for Neonatal Level II Criterion 10. A hospital with all necessary staff and with 800 or more annual births can clearly support a Level II nursery. With increases in babies born with neonatal abstinence syndrome ("NAS") and other medical conditions requiring more than a normal newborn nursery, the need for Level II providers continues to grow. NAS is an increasing problem in Kentucky. His hospital greatly appreciates the Cabinet's recognition of this situation and the proposal to allow development of Level II nurseries in hospitals with at least 800 deliveries.

(b) Response: The Cabinet appreciates the comments regarding the neonatal beds review criteria. The Cabinet recognizes the need for access to care and agrees that, if the hospitals are capable of delivering specified services, the Certificate of Need program should not be a barrier.

At the request of providers in the Bowling Green area, the Cabinet has agreed to amend the State Health Plan, I. Acute Care; D. Special Care Neonatal Beds; Review Criteria for Level II special care neonatal beds, Criterion 10, to change the threshold requirement from 800 or more annual births to 700 or more annual births.

Under the amendment filed July 13, 2017, I. Acute Care; D. Special Care Neonatal Beds; Review Criteria for Level III special care neonatal beds, Criterion 5 provides as follows:

> Notwithstanding criterion 1, an application for additional Level III special care neonatal beds by conversion of Level II special care neonatal beds to Level III special care neonatal beds shall be consistent with this Plan.

It is the Cabinet's intent to allow a hospital to have needed, qualified flexibility to respond to its neonatal patient needs. As the neonatal patients change, a hospital might find itself in need of Level III special care neonatal beds for all neonatal patients; while at another time, the hospital might need a split of Level II and III special care neonatal beds to meet the needs of its patients.

(4) Subject: Psychiatric Residential Treatment Facilities

(a) Comment: Comments regarding the changes in the State Health Plan regarding Psychiatric Residential Treatment Facilities were received from Kentucky Hospital Association, Baptist Health, and St. Clair Regional Medical Center. Those comments are included and summarized as part of this comment. (This comment relates to "II. Behavioral Health Care; B. Psychiatric Residential Treatment Facility".)

1. Michael T. Rust, Kentucky Hospital Association, submitted the following comments expressing the organization's support for revising the State Health Plan review

criteria for Psychiatric Residential Treatment Facilities (PRTF), Level II as follows: "The State Health Plan currently contains an overall limit of 145 PRTF Level II beds that can be established in the state. KHA requests an amendment to the Plan to make an exception to this limit to accommodate PRTF II beds that are established by an existing Kentucky licensed psychiatric hospital on its campus or through the use of existing space. We propose to add the following new criterion to read as follows:

"16. Notwithstanding criterion 1, an application to establish PRTF Level II beds by an existing licensed Kentucky psychiatric hospital on the hospital's campus or through the use of existing space shall be consistent with this Plan."

KHA makes this proposal to address the critical need for the establishment of PRTF II beds. This level of care was developed to treat a targeted population of children ages four to 21 with a severe emotional disability along with severe and persistent aggressive behaviors, intellectual disability, sexually acting out behaviors, or developmental disability. At the time PRTF level II was created, children with these care needs had to be sent out of state. Unfortunately, however, due to the restrictive nature of implementing regulations and the Medicaid reimbursement rate, only one PRTF II facility has been established since 2010 when the law was enacted, and that facility just opened this year.

KHA has long advocated that psychiatric hospitals should be permitted to develop PRTF II beds on their campus to complement existing inpatient and outpatient services so that hospitals can offer a full continuum of care. This helps patients move smoothly from inpatient to residential to outpatient to home, while also providing the added benefit of having immediate access to inpatient services to address acute exacerbations if a patient's condition deteriorates and they require inpatient care.

The need for PRTF II services is particularly significant today in order to treat patients with these specialized needs and, particularly, aggression. Psychiatric hospitals indicate that they cannot place these patients once they are decertified by Medicaid managed care organizations; and long delays (i.e., many months) in being able to properly discharge these patients is resulting in increased aggression on hospital units, the threatening of other patients, and staff being injured. One hospital has had to close its male adolescent unit due to staff injuries and property damage caused by such patients who cannot be placed in a residential setting once their acute condition has been addressed. Cabinet officials attended a recent meeting of KHA's Psychiatric and Chemical Forum, which is comprised of the hospitals offering psychiatric and substance use disorder treatment, to discuss this problem. All parties recognize the need for more PRTF level II facilities and are collaborating on strategies which include re-examining the current PRTF II regulations and payment. If changes are made such that hospitals can develop PRTF II services in a financially feasible manner, the State Health Plan could stand in the way unless there is an exception to the bed cap to permit psychiatric hospitals to offer this service.

Making this recommended change to the State Health Plan will not raise costs and would actually save money for the state. First, Medicaid costs would be contained because patient admission to PRTF II services would have to be authorized by Medicaid MCOs, thereby assuring that Level II services were medical necessary and the patient could not be treated in a lower level of care. Moreover, having PRTF II services readily available would save money particularly for children who are in DCBS custody. Currently, when Medicaid MCOs decertify DCBS children who need PRTF II services, because

there are none, these children must remain in acute care hospitals where DCBS then pays for their care with 100% state funds. If hospitals are able to develop PRTF II services on their campus, DCBS will save money because Medicaid MCOs would reimburse for this residential service rather than DCBS paying for acute level of care due to the lack of PRTF II services. For these many reasons, we urge the Cabinet to permit an exception to the statewide bed limit for the development of PRTF II beds by existing psychiatric hospitals on their campuses.

2. Patricia T. Mason, Baptist Health, Louisville, KY, commented that Baptist Health supports the position of KHA, which requests that language be added to the State Health Plan to permit existing licensed psychiatric hospitals to add these types of beds on the hospital campus or through use of existing space.

3. Mark J. Neff, St. Clair Regional Medical Center, Morehead, KY, stated that St. Clair Regional Medical Center requests consideration for additional revisions to the PRTF Level II criteria, to permit an exception to the statewide bed limit for the development of PRTF II beds by existing psychiatric hospitals on their campuses.

(b) Response: The Cabinet appreciates the comments regarding the psychiatric residential treatment facilities. This is an issue that is important to the Cabinet, but requires further review. The State Health Plan will not be amended at this time in response to this comment.

(5) Subject: Relocation or Transfer of Long Term Care Beds

(a) Comment: Comments regarding the changes in the State Health Plan regarding the relocation or transfer of long-term care beds were received from Kentucky Association of Health Care Facilities, Baptist Life Communities, and Carespring Healthcare Management. Those comments are included and summarized as part of this comment. (This comment relates to "III. Long-Term Care; A. Nursing Facility Beds; Review Criteria, #3".)

1. Elizabeth "Betsy" Johnson, Kentucky Association of Health Care Facilities (KAHCF), Louisville, KY, commented regarding the State Health Plan provision's on Long-Term Care, Nursing Facility Beds, specifically Review Criterion 3, related to the unlimited transfer of beds. KACHF requested that the amended language be removed entirely and that the Office of Health Policy conduct a study to determine the impact of such changes on the skilled nursing facility market. In addition, KAHCF requested that all stakeholders be included in the study and be allowed to comment on the impact of such broad changes to the nursing facility market in Kentucky.

In the alternative, KAHCF requested that the amendment to the State Health Plan reflect the requested changes made by Dr. Robert Long, CEO of Baptist Life Communities - and limited to that request alone. In a letter dated March 31, 2017, from Dr. Long, to former Executive Director of the Office of Health Policy, Dr. Paul Coomes, Dr. Long stated as follows:

Although we agree that the CON rules should continue to be limited,

> we would like to respectfully request the number [of] inventory beds needed by the entity **be reduced from 250 to 150**. This would allow other facilities to be built to meet the needs of the aging population in three counties where the aging population is growing disproportionally fast; Boone, Spencer and Oldham. (emphasis added).

The language in the proposed amendment is much broader than Dr. Long requested. Further, the proposed amendment is not related to any study or need analysis conducted by the Office of Health Policy as to whether it complies with the overall goals of the Kentucky Certificate of Need law, which is to prevent "the proliferation of health care facilities, health services and major medical equipment that increase the cost of quality health care in the commonwealth." See http://www.chfs.ky.gov/ohp/con/.

The proposed language allows unchecked relocation of beds in an ADD or contiguous county. Since some counties have a negative need in the hundreds, entire nursing facilities can be relocated under the proposed change. This will inevitably lead to the proliferation of beds in certain markets and create significant need pockets in others. Rural and economically depressed counties could face bed shortages as these would be the counties most likely to be exited. There is no evidence that the Cabinet considered the potential impact if large numbers of beds are relocated. Right now beds are accessible in all 120 counties of Kentucky. The language as drafted would create accessibility issues, job loss, and cost prohibitive travel barriers for families and loved ones.

The original State Health Plan criteria considered historic utilization rates and population growth in the counties being impacted by bed relocations - both for the county losing the beds and the proposed county of relocation. These are accepted tools frequently utilized by health care planners to predict need in certain geographic locations. As such, they are highly relevant considerations for relocation. KAHCF endorses updates to the State Health Plan that are based on actual data and analysis. To our knowledge, this has not been done.

2. Robert H. Long, Baptist Life Communities, Erlanger, KY, commented that his organization supports the amendment revising the nursing facility review criteria to allow for the transfer and/or relocation of nursing facility beds to the same county, a contiguous county, or a county within the same ADD. This revision will give his organization the flexibility needed to make strategic choices about its services in Northern Kentucky, as it is currently building a new nursing facility in Alexandria, KY to replace an old and out of date facility in Newport, KY and will ultimately have excess beds after the move that will need to be relocated. The amendment provides the flexibility to ensure that these beds are utilized where they are most needed and economically sustainable.

3. John Muller, Carespring Healthcare Management, stated that his organization opposed and requests amendment of the proposed elimination of requiring a certain bed inventory in order to transfer beds within an Area Development District. An extensive record was established in recent Cabinet hearings acknowledging the need for movement of skilled nursing beds within an ADD if certain factors were present. Consideration of bed inventories, population growth, historic utilization and maintaining adequate access are meaningful and necessary planning criteria. Carespring is supportive of a change in this criterion from 250 beds to 150 beds while the Cabinet continues to study the full effect

of this type of prudent, relatively discrete health planning, which can only be measured as it unfolds through thoughtful health planning.

(b) Response: The Cabinet appreciates the comments regarding the Relocation or Transfer of Long Term Care Beds and has decided not to further amend the language in III. Long-Term Care; A. Nursing Facility Beds; Review Criterion #3. Licensed or existing certificate of need nursing facility beds may be transferred or relocated under this Criterion within the same county, to a contiguous county, or to a county within the same Area Development District. This provision gives nursing facilities a sense of autonomy to operate their businesses with flexibility to meet patient needs.

(6) Subject: Post-Acute Rehabilitation Beds (Comments in Support)

(a) Comment: Comments regarding the changes in the State Health Plan regarding post-acute rehabilitation beds were received from many organizations, providers, and citizens. The comments in support of the proposal regarding post-acute care rehabilitation beds are included and summarized as part of this comment. (This comment relates to "III. Long-Term Care; A. Nursing Facility Beds; Review Criteria, #5".)

1. Darryl Wellinghoff, Mainstreet Health, Carmel, IN, commented that he fully supports 900 KAR 5:020. Mainstreet Health designs, develops, owns, and operates a portfolio of post-acute care facilities called Rapid Recovery Centers that provide a clear path to home for patients who are being discharged from the hospital following a surgical procedure or getting care for a complex medical condition. They operate under a skilled nursing license but are not traditional nursing homes. They accept patients eighteen (18) and older and any health plan that covers short-term rehabilitation, and have an average length of stay of fourteen (14) days. He described their business practices, including that patients receive a daily physician visit; have an RN to patient ratio of 1:10; employ their own therapists; have technology; are Joint Commission Accredited; are staffed and equipped to take a broad spectrum of acuity, early, allowing sooner hospital discharges; interact and communicate with hospitals and physicians using a seamless technology platform; use electronic medical records; and have a bed reservation system. He stated that the three (3) billion dollar revenue of nursing homes has resulted in longer nursing facility stays, higher costs of care, higher co-pays, and high return to hospital rates. The State Health Plan revisions will allow new models of care that are strictly focused on managing patients for that short window of time between hospital and home. In his company's rapid recovery model, a physician determines when the patient goes home, rather than an administrator. The impact to hospitals and physicians include lower rates of readmission, placement challenges for higher acuity patients, more days than necessary in costly hospital beds, and a complete lack of transparency into the care of a patient once discharged. In their rapid recovery model, his facilities work closely with quality long-term care facilities and home health agencies to provide coordinated care, with the goal of ensuring that the patients treated receive the best care possible, at the lowest cost possible, and in a setting that is conducive for recovery. The Rapid Recovery Centers bring a level of innovation to that short period of time between the hospital and home when the patient requires a clinical team that is focused on their specific needs.

Amending the State Health Plan to allow for this type of innovation will have a dramatic effect on patient outcomes and the economics of care.

2. Jeff Key, Rapid Recovery Centers, Mainstreet Health, Carmel, IN, stated that his company is looking to build brand new, short-stay, higher-acuity transitional care buildings across the country. Their product differs from other care providers in the following ways: clinical excellence; technology and communication; culture and patient experience; and purpose-built design.

They want to begin building in Kentucky for the initial phase of four (4) locations, providing over 500 full-time jobs with an average salary of $65,000 per year. They hired America's Research Group to conduct a survey of over 17,000 Kentuckians, showing that seventy-one (71) percent favored a new short-term facility built locally in their community. Their goal is to work with the existing nursing home businesses, the hospitals, and the home health care agencies to provide the most excellent care available.

The only organized opposition they are aware of comes from the Nursing Home Association, but their opposition is purely for financial reasons.

Kentucky ranked 50th out of fifty-one on a Scorecard funded by the AARP Foundation, the Commonwealth Fund, and the SCAN Foundation, which looked at the performance of the fifty (50) states and the District of Columba in the following categories: affordability and access; choice of setting and provider; quality of life and quality of care; support for family caregivers; and effective transition between the nursing home, hospital, and home. According to the U.S. News and World Report, Kentucky has the fourth highest readmission rate in the nation. Additionally, Kentucky only has 17% five-star properties, with 43% of all Kentucky properties being a one or two star.

Their proposal establishes inclusive language so anyone in the entire market can establish these facilities.

3. Mark Fritz, Mainstreet Health, Carmel, IN, stated that he was president of Mainstreet operations for Arizona and Texas. This proposal will allow companies to bring a health care program in to this SNF licensure that focuses on the patient and getting them back home as quickly and safely as possible. Mainstreet and other operators have been focused for years on a medical concept that involves having physicians in the facilities every day along with highly trained staff that specialize in the different disease states that they are treating. In this model, doctors make the decisions about each patient's health instead of the nursing home staff. Physicians determine discharge dates based on the patient's needs. This model provides a design-built, highly sophisticated facility that looks and operates very differently from a typical nursing home and is much more comparable to an inpatient rehab facility. Mainstreet takes patients more quickly from hospitals and gets them back home typically within fourteen (14) days on average. They work with all payor groups that are appropriate for short-term rehabilitation and returning home.

AARP recently published a Scorecard that ranks Kentucky 50th in performance across dimensions in long-term services and supports compared to other states. In addition, the Commonwealth Fund State Health System Performance Scoreboard of 2017 revealed that Kentucky has the 45th highest thirty (30) day hospital readmission rate compared to other states. The CON system protects the operators who consider nearly

the worst care in the country to be perfectly fine.

Kentucky's average length of stay for Medicaid SNF beneficiaries is fifty-one (51) days. Contrast this with a fourteen (14) to twenty (20) day average length of stay in a typical transitional care facility. If this adjustment to the CON criteria is enacted, Kentuckians can expect average length of stay to be reduced by thirty-one (31) to thirty-seven (37) days. Kentucky's CON system protects the status quo that equates to millions of dollars annually and unnecessary skilled nursing days. The return-to-hospital rate shows that patients are not getting special care or better care because they are being sent back to the hospital at an alarming rate, 45th worst in the nation.

There are good operators in Kentucky who are taking good care of their residents, but for most Kentucky SNFs, short-term rehabilitation is not their core competency.

4. Michael T. Rust, Kentucky Hospital Association, submitted the following comments expressing the support of the Cabinet's proposal to amend the State Health Plan to provide health care facilities, including acute care hospitals, with the opportunity to establish short term post acute care services for the purpose of transitional care:

"**Challenges in Post Acute/Transitional Care**

"Hospital Readmissions Reduction Program – The Affordable Care Act (ACA) established the Hospital Readmissions Reduction Program (HRRP), which requires CMS to reduce payments to acute hospitals with high rates of 30 day readmissions. During initial implementation of the rule, the HRRP program measured 30 day all-cause readmissions for Medicare beneficiaries with a diagnosis of acute myocardial infarction (AMI), heart failure (HF), or pneumonia (PN). The HRRP program has expanded substantially in recent years. The number of conditions for which CMS tracks readmissions and applies a penalty has grown to also include new pneumonia diagnoses, coronary artery bypass graft surgery, total hip and knee replacement and Chronic Obstructive Pulmonary Disease (COPD). Hospitals are penalized up to 3% of their total Medicare payments for all care based on their readmission rate in comparison to all other hospitals. The penalty has grown from $290 million in 2013 to $860 million in 2017. For Kentucky, the estimated fiscal year penalty is $18 million in 2017 compared to $10.7 million in 2015. States like Kentucky are at much greater risk for readmissions penalties because of the impact of socio-demographic factors. Numerous studies, including one published in *Health Affairs i*n May 2014, have found that patients living in higher rates of poverty are much more likely (24% greater risk) to be readmitted than other patients. There are a number of socio-demographic factors that also contribute to this readmission disparity including education level, transportation and health literacy. Congress recently passed legislation to address the penalty disparity that states like Kentucky experience. This disparity is a clear indication that Kentucky needs additional resources and opportunities for hospitals to follow patients discharged from the hospital to assure they have the most appropriate and high quality post acute care as well as access to other resources at home like those services provided by home health agencies.

"Bundled Payment Models – Bundled payment models have been studied since the 1980s as a means to improve quality of care and lower cost for an overall episode of care. With the passage of the Patient Protection and Affordable Care Act, Congress mandated that Medicare implement bundled payment programs for hospitals. Beginning in Fiscal Year 2015, Medicare implemented the first widespread bundled payment

program called Comprehensive Care for Joint Replacement (CCJR) which affected hospitals in metropolitan statistical areas including areas in Kentucky. The CCJR is a 90 day episode payment program which means hospitals are financially responsible for the total cost of all services used by a patient beginning three days prior to a joint replacement procedure until 90 days post discharge. Hospitals are required to manage the full continuum of care for the episode including any complications that arise with the patient as well as to coordinate post acute care such as inpatient rehabilitation, skilled nursing facility care, home health and outpatient rehabilitation. Under bundled payments, all post acute providers continue to bill and receive payment from Medicare; however, at the end of the year, the hospital initially treating the patient is penalized if the total costs from all providers within the 90 day period exceed a pre-determined regional average. Hospitals cannot assure the quality of services, costs or outcomes of post acute providers, but the hospital remains fiscally responsible for the episodic payment!

"Medicare has proposed to expand the bundled payment programs to include expansion of the CCJR and the implementation of a Cardiac Rehabilitation Incentive Payment Program. This demonstrates the intent of Medicare to continue to expand cost savings efforts by placing the burden of financial risk on hospitals While the expansion has been delayed by Medicare for continued studying of the issue, it is expected to be implemented in the near future. It is also important to note that Medicare is implementing bundled payment programs in health service lines which have historically been more profitable for hospitals, and have allowed hospitals to subsidize care such as trauma care and obstetrics which hospitals typically lose money on.

"Accountable Care Organizations – ACOs are organizations of doctors, hospitals or other providers which come together to manage the health of a population of Medicare beneficiaries. Medicare pays the ACO a set amount to manage the health and health care services for all the patients attributed to the ACO. The goal of ACO programs is to assure more coordinated care, less duplication of health care services and better outcomes overall, especially for patients with chronic diseases or multiple chronic diseases. There are three types of Medicare ACO models, all designed for the ACO provider organizations, usually hospitals, to manage care and potentially share in savings generated along with Medicare if the ACO is successful in reducing health care costs. This is not guaranteed. In fact, early ACOs had significant challenges in achieving savings. Providers adopting the ACO model of care early on and which operated under a risk-based (financial) model were for the most part unsuccessful in achieving the desired savings to make the program financially viable for both the ACO and Medicare.

"ACOs are saddled with significant start up costs including technology and coordination costs. So, while an ACO may be successful in managing patient care and may have a positive margin from patient care, it does not mean the ACO will be able to recoup the significant costs associated with the start-up of the organization. Furthermore, patients attributed to an ACO maintain a degree of autonomy in choosing providers and have little to no incentive to choose the best, most efficient and high quality provider. This exacerbates the challenges for the ACO in achieving savings, which is why it is important that hospitals assuming financial risk have the ability to provide post acute services directly, so that cost efficiency and high quality can be assured rather than being captive to use existing lower quality providers.

"Existing Post Acute Services Challenges in Kentucky– It is clear that the trend

under the Medicare program is to shift the financial risk of caring for patients from Medicare to hospitals. This trend is becoming more appealing in the private insurance sector as well, typically with pilot programs and other contractual negotiations. Of significant concern is that patients have not been incentivized to make the best quality and cost-efficient choices in choosing their post acute care services. In fact, hospitals are required to provide patients with numerous options for where they can access post acute services. In many communities, there are a limited number or no available high quality services such as long term care facilities.

"The Centers for Medicare and Medicaid Services (CMS) has developed a quality evaluation system called Nursing Home Compare. CMS publishes publicly on the Nursing Home Compare web site nursing home ratings on a scale of five stars to one star. Five stars means the center has a quality rating much above average. Four stars reflect above average. Three stars reflect average and two and one star represents below average. There are 277 Kentucky Long Term Care (LTC) facilities evaluated on Nursing Home Compare but only 50 (18%) are five star and 60 (22%) are four stars. That means 60% of the LTC facilities in the state, available to provide short term, post acute care to patients discharged from hospitals, *provide average to below average care*. Therefore, there is an enormous challenge for hospitals trying to place patients upon discharge in the most appropriate, high quality nursing homes. Twenty-seven of the LTC centers evaluated on Nursing Home Compare are hospital-based nursing facilities. Of these, 21 of the 27 (78%) are rated as four or five star facilities. Hospital-based LTC facilities in Kentucky demonstrate a higher level of quality according to Nursing Home Compare in comparison to the rate of high quality for all non-hospital affiliated LTC facilities. Hospitals should be provided the opportunity to establish short-term post acute rehabilitation or transitional care services for their patients, especially as hospitals are at risk for the final outcome and cost of patient care due to Medicare-driven programs like the HRRP, ACOs and bundled payment programs.

"KHA recently polled our members regarding challenges in placing patients in post-acute settings for short term transitional care. We received several responses from facilities, representing hospitals and health systems in each region of the state. The following summarizes the challenges in placement:

Question	Range/Response
Average time it takes to place a complex patient (e.g. obese, or payor issues) in a SNF	2 – 7 days, some report months
Average time it takes to place behavioral health and sex offenders	7-30 days, often 90 days +
Number of patients placed outside of service area because of lack of availability of SNF beds	2 plus patients a month
Percent of patients discharged to SNF care	15% - 25%

**all responders site the challenge of placing patients with behavioral health patients in spite of their being 5 Star SNFs in close proximity of the hospital.*

"Thus while the long term care industry claims to have available beds, hospitals

report having many patients needing nursing home services that long term care facilities will not accept. KHA commends the Cabinet for amending the State Health Plan to provide acute care hospitals with the opportunity to establish short-term post acute care services for the purpose of transitional care. As described above, hospitals are being required to be at financial risk for the full range of patient care, include post-acute outcomes. Hospitals find it extremely difficult to place patients in high quality SNFs within close proximity of their facility or patients' homes. Furthermore, hospitals report that even when there are five Star LTC facilities in close proximity, there is still a significant delay in placing complex patients with a lag time of between three and 30 days, and with some, even months longer. Under all existing reimbursement policies, both traditional and advanced value-based systems, this is a cost drain on both the hospital and the health care delivery system as a whole. By allowing hospitals to establish short term transitional care units, hospitals will have the flexibility to transition patients more efficiently to the most appropriate, high quality setting. Finally, Nursing Home Compare data demonstrates that LTC/SNF facilities affiliated with hospitals have a much higher rate of quality than those not affiliated with a hospital, overall. We commend the Cabinet for allowing hospitals to establish limited high quality services for transitional care which will improve outcomes for patients and control costs more effectively for our health care system in Kentucky."

5. Patricia T. Mason, Baptist Health, Louisville, KY, commented that Baptist Health commends the Cabinet for consideration of the special needs of patients who must have post-acute rehabilitation as part of their recovery process and the need to provide these services in the most cost effective setting possible. As Medicare and other payers continue to expand cost saving efforts by placing the burden of financial risk on hospitals, it is critical that hospitals have more flexibility in providing these types of services. Hospitals should be provided the opportunity to establish short-term post-acute rehabilitation or transitional care services for their patients, especially as hospitals are increasingly at risk for the final outcome and cost of patient care. Baptist Health therefore supports additional language in the State Health Plan that allows for the establishment of nursing home beds for the provision of post-acute rehabilitation services.

6. Julia Crigler, Americans for Prosperity, stated that her organization champions the free market to improve the lives of Kentuckians and applauds the Cabinet for the sensible language proposed in the State Health Plan regarding post-acute care. Innovation happens fast and in the health care space, new changes and investment are a welcome development in Kentucky, where outcomes are lackluster. Recent U.S. News / McKinsey Data shows Kentucky has the fourth-most hospital readmissions in the country. Of the thirty-eight (38) hospitals nationwide facing the highest penalties for readmissions between October 1, 2015 and September 16, 2016, twenty (20) percent were based in Kentucky. The bridge of care between the hospital and home, or "post-acute care" is often the missing link.

Facilities solely focused on post-acute care are a new market innovation that are changing care in many states. These cutting-edge facilities are dedicated to shorter stays. This is a distinct patient profile consisting of patients who, with the right kind of personalized, doctor-driven care, return home in a matter of weeks. Unfortunately,

Kentucky hasn't been able to enjoy the benefits of these new facilities due to a moratorium on new beds that lumps this innovative model with long-term facilities/nursing homes. Thankfully, this proposed amendment would allow for new short-term facilities to be built if the average length of stay is under three (3) weeks. That's compared with fifty-five (55) days for other nursing facilities in Kentucky.

This is a wise, market-friendly approach. Many patients, whether Medicare or private payer, do not need or wish to recover at a nursing home. Post-acute care is simply another option that, when clinically appropriate, offers a specific setting for the critical weeks of recovery following a procedure. In other states, this model is lowering rehospitalization rates, shortening lengths of stay, increasing patient satisfaction, and driving down costs per patient.

Where there is innovation in an industry, there are also often powerful incumbents that attempt to keep new players out of the market. The Kentucky nursing homes' industry trade group is pressuring the Cabinet to drop the new rule allowing for new post-acute facilities because the average occupancy of their facilities has declined to eighty-seven (87) percent and there is space available. It seems the established nursing homes in Kentucky want the government to protect them from the competition of a new, unique model of care. This attitude runs county to Kentucky's growing reputation as a state that welcomes new investment, jobs, and business approaches. More choices, not fewer, is the way to ensure that Kentucky consumers get the kind of care they want at the best possible price. Hospitals, post-acute care facilities, long-term facilities, and in-home care will all play a vital role in the health care system of the future.

7. Joshua H. Crawford, Pegasus Institute, stated that the mission of his organization is to provide public policy research and solutions that help improve the lives of all Kentuckians. Their focus is on using data-driven research to create a 21st century state. The 21st Century, like the centuries before it, will only be as successful as it is innovative. In healthcare, like far too many other things, Kentucky is at the bottom of all the wrong rankings. This is, at least in part, because of innovation-stifling certificate of need regulations. Recent U.S. News Data shows Kentucky has the fourth highest hospital readmission rate in the country. Of the thirty-eight (38) hospitals nationwide facing the highest penalties for readmissions between October 1, 2015 and September 16, 2016, twenty (20) percent were based in Kentucky. Only innovation, competition, and patient choice can help improve those numbers.

The average occupancy rate in Kentucky may be at eighty-seven (87) percent with the national average being eighty-two (82) percent, but focusing on occupancy rates ignores the underlying reasons as to why the beds are unoccupied. The average nursing home nationwide is around forty (40) years old and is incapable of offering the services consumers want or need. In fact, traditional nursing homes have become increasingly unpopular. According to a survey conducted by the AARP, eighty-nine (89) percent of people over fifty (50) said they would prefer to remain in their homes as they age.

Facilities solely focused on post-acute care serve this role in a growing number of states. These cutting-edge facilities are dedicated to shorter stays and serve a need and group of patients who are currently underserved by traditional nursing homes. The goal of post-acute care facilities is, in a matter of a few weeks, to get patients back to where eighty-nine (89) percent of Americans over age fifty (50) want to be, home. Kentuckians,

however, have yet to benefit from this innovation because of a prohibition on new beds that includes these innovative facilities and traditional nursing homes. The Cabinet's new State Health Plan would change that and allow Kentuckians options when they previously had none.

The importance of these facilities cannot be understated. In fact, a recent Hospitals and Health Networks Magazine blog highlighted the importance of post-acute care partners in hospital success, reputation, and bottom-line moving forward. It recognized the comparative advantage that these facilities have in cost and quality. Kentucky should take advantage of this innovation and can by adopting the post-acute care language in 900 KAR 5:020.

8. Gatewood Robbins, Lexington, KY; Keith Johnson, Robbins Enterprises, Elizabethtown, KY; Mary Key, Jeff Key, Joe Crum, Ashwani K. Anand, Glenn Petersen, Marlinta Comer, Tiffany L. Hart, Barbara Key, Jerry Doss, Sylvia Doss, Patricia Cardin, Brian Cardin, Nina Cardin, Glendale, KY; Kelly Emerine, Afton Proffitt, Braden Proffitt, James N. Williams, John D. Pawley, Gale Williams, Deborah L. Smith, John Melloan, Joni Melloan, Amanda Purvis, Elizabethtown, Ky; Aaron Hart, Anita G. Hart, Sonora, KY; Bryan W. Cole, DeVon March, Mark J. Harvey, Louisville, KY; Karen Clines, Maxine Cheek, Brownsville, KY; Shanda M. Graves, Cathy LaFitte, Tyna McDonald, Emily Towe, Pat Pfeiffer, Dr. Grant G. Watkins, Dr. Colin G. Fultz, Edwina Jordan, Michelle Watkins, Sydney Hurt, Morgan Keen, Scottsville, KY; Walton Key, Dorothy Key, Shelby Key, Bowling Green; Jessie Key, Nashville, TN; Cyndi Osborne, Rineyville, KY; Melissa Brown, Fountain Run, KY; Manuel Montgomery, Donald McFarland, Regina Carty, Pansy Blanton, Sharon Blanton Howard, Carson Montgomery, Oscar Green, Jr., Thelma J. Green, Vickie Green, Mark Green, Salyersville, KY; Brady Murray, Missy Kinnaird, David Moore, Alexis Poteet, Brad Hale, Brooke Sanders, Teresa Murray, Bailey Poteet, Juli Wade, Hannah Robey, Nancy E. Uhls, Stephanie Cornwell, Ali Poteet, Ricky Murray, Thmarsha Thompson, Jack N. Wade, Sierra Escue, Franklin, KY; Taylor Alford, Auburn, KY; Brooklyn Bean, Konner Whittinghill, Jordan Davis, Joel Davis, Kendall Whittinghill, Debbie Wells, Becky Justis, Brianna Whittinghill, Cindi Whittinghill, Theresa Lamar, Darrel Basil, Debbie Gibson, Garrett Mayse, Caitlan Poteet, Shane Wells, Tommy Gibson, Amanda Woodcock, Jeannie Basil, Barbara Davis, Hunter Bean, Helena Carroll, Cynthia Davis, Jourdian Lamar, Nathanial Lamar, Kyndal Whittinghill, Olivia Davis, Brownsville, KY; Sue Sanders, Smiths Grove, KY; Tiffany Mayse, Lindseyville, KY; Savannah McStoots, Sierra McStoots, and Charlie McStoots, Mammoth Cave, KY; Brittany Whittinghill, Kyle Whittinghill, Morgantown, KY; and Mike Prin, Scott Helton, Gerald Howard, Johnni Green, Terry L. Watson, and Tammy Gays; provided the following comments: The amendment to 900 KAR 5:020 is supported for multiple reasons. First, if skilled nursing care is needed after a hospital stay, they would prefer to stay for the shortest time possible, in a new facility that specializes in rehabilitation vs. a nursing home that is predominantly long-term care with some rehabilitation. Second, the amendment will change the focus to the needs of the patient and away from the business needs of the nursing home. This is definitely a step in the right direction for the state of Kentucky. Lastly, having a new facility with state-of-the-art rehabilitation will make a big difference in the quality of life for the citizens of Kentucky.

9. Jan Helson, Helson Development Corporation, Louisville, KY, stated that she supports the Cabinet's proposal for short-term care in the State Health Plan. This new and innovative model to provide short-term rehabilitation options to patients will translate to higher quality healthcare with intentionality. The single patient option of nursing homes for post-surgery rehabilitation forces patients to rehab in nursing home facilities that are not equipped to administer intentional high-quality services. Nursing home facilities expose patients to diverse medical conditions, viruses, and germs that they should not be exposed to as an otherwise health post-op patient. The nursing home facilities often lack the in-house facilities and expertise needed to ensure that all patients have an optimal opportunity for a successful recovery. In addition to the health benefits, opening the market to these new facilities would have a positive economic impact on the Commonwealth and demonstrate commitment to a free open market to stimulate competition and ensure quality health care options for citizens.

10. Danny Glick and Helen Johnson, Hillsdale Furniture, Louisville, KY, and Erin Moore stated that the Cabinet's proposal for short-term care in the State Health Plan is the right direction for Kentucky. The post-acute care format can bring much better care and more options for Kentucky. We do not need restrictions in this area and this option will give more choices.

11. Valerie Patrick; Kerry K. Howard, Licking Valley RECC; and Jesse Rudd II, Parkway Pharmacy, commented that the proposal for short-term care facilities will improve quality of life and bring jobs to Eastern Kentucky. It's great to give more options on short-term care. Health care in that gap time between the hospital and home can make a positive difference in lives. Allowing people to build new facilities will also be beneficial for the area economy.

12. Paul Patton, University of Pikeville and One East Kentucky, Pikeville, KY, stated that he is Chair of the One East Kentucky organization tasked with improving and diversifying the economy of Eastern Kentucky. He supports the Cabinet's proposal to allow for short-term healthcare facilities to serve patients between the hospital and home. He believes it will provide citizens with better and more affordable healthcare. This new service has the potential to create more jobs in the area, which are desperately needed.

13. Joseph M. (Mike) Exton, City of Pioneer Village and Bullitt Co. GOP, Pioneer Village KY, stated that he supports the Cabinet's proposal for short-term care in the state health plan. The short-acute care model can bring a new model and new construction, jobs, and services to the area. We should continue to look for more market-based changes that encourage new investment, ideas, and high-paying jobs in Kentucky. This proposal also adds the potential to reduce Medicare cost related to recovery and rehab.

14. Robert E. Robbins, Robbins Enterprises, Elizabethtown, KY, commented that he is a retired surgeon and has been involved in developing a retirement community in Elizabethtown, including a sixty-three (63) unit assisted living facility already built, a ninety-six (96) unit independent living facility under construction, and a more up-scale sixty-four (64) unit independent living apartment facility financed and ready for

construction to start next spring. He has been trying to get permission to build a 112 bed skilled nursing facility for the last three (3) years but cannot attract a skilled nursing home to campus. The modern nursing home that has existed for fifty (50) years has deteriorated to a facility that is deplorable in the treatment provided to residents, with three (3) patients to a room, with flimsy curtains and one shared bathroom. Patients deserve better. Nursing home operators are simply managers who are forced to furnish subpar care. The real problem arises from the nursing home owners who own the building and CON, who charge high prices to managers and resist upgrades in care because their revenue would decrease. A large out-of-state real estate investment trust (REIT) owns a local nursing home and has resisted building a new nursing home because it would decrease revenue; however, that nursing home's management group is willing to build a new nursing home. Thus, the project has been on hold for the last three (3) years.

The amendment to 900 KAR 5:020 is supported for multiple reasons. First, if skilled nursing care is needed after a hospital stay, they would prefer to stay for the shortest time possible, in a new facility that specializes in rehabilitation vs. a nursing home that is predominantly long-term care with some rehabilitation. Second, the amendment will change the focus to the needs of the patient and away from the business needs of the nursing home. This is definitely a step in the right direction for the state of Kentucky. Lastly, having a new facility with state-of-the-art rehabilitation will make a big difference in the quality of life for the citizens of Kentucky.

15. Timothy D. Helson, Louisville, KY, commented that he supports the proposal for short-term care facilities in the State Health Plan. This proposal will provide a much needed, new and improved, alternative to nursing homes for post-acute care patients to rehab. The current system of putting rehab patients in nursing homes does not provide the quality of care they need to properly engage in rehab and recuperate to a normal, healthy state. Anything that a market need is opened to the free market, there is an economic boost that should be present in all businesses. This proposal will improve the health of Kentucky's citizens and have a positive economic impact.

16. Mark Sanders, Summit Engineering, Inc., and One East Kentucky; Leisha Maynard, Citizens Bank, Paintsville, KY; Allen Gillum, East Kentucky Network, LLC, dba Appalachian Wireless, Ivel, KY; James M. Shepherd, Magoffin County Health Department and City of Salyersville, Salyersville, KY; and Duran Hall, Maverick Insurance Group, LLC, Louisville, KY, stated that the Cabinet for Health and Family Services deserves a lot of credit for proposing changes to the State Health Plan. Allowing for short-term care between hospital and home is a big step forward. It will help improve health outcomes in East Kentucky and also help attract new investment dollars.

17. Michael O. Buchanon, Warren County Judge Executive, Bowling Green, KY, stated that he supported 900 KAR 5:020. Opening Kentucky up to new models, investment, and business is exactly in keeping with the tone set by the Governor and General Assembly. There is great need for skilled nursing facilities that focus on post-acute care. These post-acute care facilities are a bridge between hospital and home and will mean more choice for patients. Kentucky should welcome the new multi-million dollar post-acute care facility by a company that wants to invest in Kentucky and Warren County,

as post-acute care is an essential part of quality health care.

18. Patricia J. Stansbury, Wimsatt Management Co., Inc., Louisville, KY, stated that the Cabinet's proposal for short-term care would be good for the state. We need more options in our health care, not less. The gap between hospital and home can be better addressed with the specialized care of the post-acute model proposed. This proposal can only help the state of Kentucky.

19. Robin Boren, Wimsatt Management Co., Inc., Louisville, KY, stated that it is appalling that the hospitals and nursing homes are trying to block these facilities from coming in to Kentucky. Any form of care that can benefit not only the patient, but also their families, should be welcomed with open arms. Instead of allowing healthcare to be greedy and keep all the monies for themselves, we should look at the patients' well-being and overall state of mind. When a person hears of having to enter a retirement home, it gives them a sense of fear of never being allowed to go home again. If they are given another alternative, such as a post-acute care model, they will have the sense of having a say in their total treatment and more people will be willing to have surgery in the first place.

20. Mary Wimsatt Glick, Wimsatt Realty, Louisville, KY, and Deborah Walker, Louisville, KY, stated that the Cabinet's proposal for short-term care in the State Health Plan is wise. The post-acute care model can bring better, more specialized care that is focused on the gap between the hospital and home. She wants more options, not less, in healthcare. Let the free market decide.

21. Russ Ranallo, Owensboro Health, Owensboro, KY; stated that Owensboro Health supports the Kentucky Hospital Association comments and wanted to supplement those comments regarding Post-Acute/Transitional Care Services (which are summarized as Comment (6)(a)4. KHA outlines readmission penalties, bundled payment models, and accountable care organizations and the impact of Post-Acute Care on hospitals. Owensboro Health wants to add the Medicare Spending Per Beneficiary (MSPB) measure to the list. The MSPB is a CMS measure of spending for an episode of care that covers not only the inpatient stay but the care immediately prior to and thirty (30) days post the inpatient stay. The MSPB accounts for twenty-five (25) percent of a hospital's CMS Value Based Performance (VBP) score. Two (2) percent of Medicare inpatient payments are at risk in 2018 under the CMS-VBP programs. It is important that hospitals are able to impact post acute care services to enhance and improve performance in CMS-VBP indicators.

Additionally, he stated that Owensboro Health appreciates the Cabinet recognizing the need of hospitals to allow transfer or relocation of nursing facility beds. They request consideration be given to not limit the average length of stay to twenty-one (21) days. As the care delivery and payment models changes to put the hospitals at more risk, hospitals need the flexibility to address many sites of care to be successful in these models.

(b) Response: The Cabinet appreciates the comments regarding the Post-Acute Rehabilitation Beds. The Cabinet will amend the State Health Plan in response to these

comments. Specifically, the Cabinet will amend the Review Criterion #5 to establish a Post-Acute Transitional Care Pilot Program. The Cabinet recognizes that Kentucky ranks forty-ninth (49th) out of the fifty (50) states in hospital readmission rates, which creates a financial burden for hospitals located in the Commonwealth of Kentucky. The pilot program will address Kentucky's high hospital readmission rates pursuant to this criterion 5. The new criterion authorizes no more than a total of four (4) applications, with up to two (2) located in a rural Core Based Statistical Area (CBSA) and up to two (2) located in an urban CBSA, to establish nursing facility beds in a freestanding facility or as part of an existing facility if the applicant satisfies all other requirements of certificate of need, including the formal review, and demonstrates: the annual average length of stay for the proposed nursing facility beds shall not exceed twenty-one (21) days; readmission rates for hospitals discharging patients to the proposed nursing facility beds will decrease; seventy-five (75) percent or more of patients discharged from the proposed nursing facility beds will transition to a home or community based setting; and the applicant agrees to submit an annual report on the average length of stay within their nursing facility beds, hospital readmission rates, and discharge settings to the Cabinet for Health and Family Services.

Additionally, in the Need Assessment for Nursing Facility Beds formula, the Cabinet will specify that the calculation for "C", which is the average number of empty beds in the county of application and all Kentucky counties contiguous to the county of application, shall not include nursing facility beds approved pursuant to the Post-Acute Transitional Care Pilot Program.

The average length of stay was established at twenty-one (21) days to keep the focus of these facilities as post-acute rehabilitation beds for patients returning to the home setting. In 2013, Governor Beshear's administration commissioned a study of Kentucky's healthcare service capacity, which demonstrated that nursing facilities are at or above capacity, suggested the emergence of a "pent-up demand", and found that nursing facility care is a major component of state Medicaid budgets (second only to acute care). These findings have not been addressed. In addition, Kentucky's current average length of stay for Medicaid SNF beneficiaries is fifty-one (51) days, but the average length of stay for the proposed nursing facility beds shall not exceed twenty-one (21) days. Furthermore, the post-acute rehabilitation service is designed to reduce hospital readmission and recent U.S. News Data shows Kentucky has the fourth highest hospital readmission rate in the country. Kentucky has gained national recognition for poor quality long term care and this criterion provides a new setting to enable patient choice within the spectrum of care. It is important to note that the criterion has inclusive language, enabling the criterion to be met by hospitals, skilled nursing facilities, and new facilities.

(7) Subject: Post-Acute Rehabilitation Beds (Comments in Opposition)

(a) Comment: Comments regarding the changes in the State Health Plan regarding post-acute rehabilitation beds were received from many organizations, providers, and citizens. The comments in opposition to the proposal regarding post-acute care rehabilitation beds are included and summarized as part of this comment. (This comment relates to "III. Long-Term Care; A. Nursing Facility Beds; Review Criteria, #5".)

1. Elizabeth “Betsy” Johnson, Kentucky Association of Health Care Facilities (KAHCF), Louisville, KY, commented regarding the State Health Plan provision’s on Long-Term Care, Nursing Facility Beds, specifically Review Criterion 5, related to short-term rehabilitation beds. KAHCF strongly opposes any exception to the short-term rehabilitation "nursing home" State Health Plan need criteria. Currently, the Office of Health Policy's 2016 Long Term Care Bed Need shows a statewide surplus of 18,563 for "long-term care beds," which includes "nursing home beds." The only difference between a "nursing home" bed and other long-term care bed is its very limited payor source - Medicare only. From a pure planning perspective, the Cabinet should be skeptical of any proposal that intentionally limits accessibility.

KAHCF understands that two separate groups are pushing for this dramatic change to the State Health Plan need criteria for short-term rehabilitation beds: (1) the Kentucky Hospital Association and (2) "Rapid Recovery Center" - from Mainstreet Health. Both cite to very different reasons for this amendment; however, both positions are uninformed and do not take into account that these services are already being provided to Kentucky citizens.

Although KHA consistently lobbies against community providers being able to circumvent the CON laws to build free-standing facilities to provide MRI and ASC services because KHA believes that such free-standing facilities "destabilize" the health care market place, KHA's suggested proposal does just that - it will destabilize post-acute care services in Kentucky. KHA's proposal would place Kentucky's existing skilled nursing facilities in significant financial jeopardy by cherry picking and taking away a resident population that allows facilities to maintain a balanced case mix, and negatively affect the exceptional quality of care that Kentucky's skilled nursing facilities are currently able to provide.

The bundled payment systems argument (which looks unlikely to continue under the Trump administration) and ACO participation is all "smoke and mirrors." The point behind mandatory bundling programs, such as the Comprehensive Care for Joint Replacement program, is to incentivize hospitals to partner in unique and innovative ways with post-acute providers to manage the care for patients and ensure seamless transitions of care over an episode of care. It requires hospitals and skilled nursing facilities to collaborate on care protocols, processes, information exchange, and staffing support. The KHA's proposed language is contradictory to establishing a fluid health care continuum. On the other hand, the KAHCF’s skilled nursing facility membership welcomes such collaboration with hospital partners. KAHCF members have been willing and able to collaborate with hospitals on Medicare bundle payments initiatives throughout the Commonwealth of Kentucky. Success is determined by the willingness to partner and collaborate, not the ability to have complete control over the patient over an episode of care. Skilled nursing facilities are best positioned to care for these types of patients - hospitals are not.

KAHCF believes that the arguments by Mainstreet in support of this proposal for additional short-term rehabilitation nursing home beds are also misguided. First, "Rapid Recovery Centers" is a marketing term, not a new model of care. What is defined and described in their proposal is not the "new health care product." Kentucky-based skilled nursing centers are providing short-term rehab services all over the state. Mainstreet will certify these beds as Medicare beds; they will bill Medicare for these short-term

rehabilitation services just as the current skilled nursing facilities do for the same services. Allowing Mainstreet's proposed changes would be tantamount to giving away for free what Kentucky providers have paid hundreds of millions of dollars to provide through the Certificate of Need process.

There is a plethora of short-term rehabilitation services available in Kentucky. These beds are located in acute care hospitals, rehabilitation facilities, and freestanding long-term care centers. These providers offer short-term rehab in private rooms with experienced therapists and other clinicians. The proposed SHP amendment will not create new jobs in Kentucky. Kentucky's skilled nursing facilities alone employ over 30,000 people across the Commonwealth. If Mainstreet builds Rapid Recovery Centers (in the Louisville and Bowling Green markets as they described in public testimony), they will simply hire individuals from existing providers, not create new jobs. Providers in the health care continuum are hiring individuals right now. Cannibalizing existing health care providers' work force does not constitute the creation of jobs.

Mainstreet's model does not guarantee higher quality services or shorter stays than existing providers. Mainstreet will be a Medicare-certified provider like the existing skilled nursing facilities operating today. Mainstreet will be subject to the same rules established by Medicare regarding lengths of stay and the same regulatory oversight established by the Centers for Medicare and Medicaid Services and the Kentucky Office of Inspector General. Mainstreet’s proposal will not result in a positive economic impact on Kentucky. This proposal would redirect the existing economic impact that Kentucky's skilled nursing facilities already generate - and eventually drive the current skilled nursing facility operators out of business by redirecting Medicare dollars away from the current providers.

In Kentucky today, skilled nursing facilities' revenue consists of twenty-eight (28) percent Medicare, fifty-five (55) percent Medicaid, and the rest is private pay or commercial insurance. Mainstreet readily admits that it will not be a Medicaid participating provider. Mainstreet also admits that it will only build in urban areas and not rural areas of Kentucky. While statements were made regarding caring for the Medicaid population as well, nursing home beds cannot be certified for Medicaid participation.

KAHCF is aware of two (2) letters filed in support of the proposed changes to 900 KAR 5:020 from Americans for Prosperity (AFP) and Pegasus Institute. Both letters quoted from U.S. News/McKinsey Data stating that Kentucky has the 4th highest hospital re-admission rate in the country. However, AFP and Pegasus completely ignore the general health and acuity of those seeking services in nursing facilities and hospitals around the state. In the 2016 America's Health Rankings Senior Report, Kentucky was ranked 7th in the nation for nursing home residents who were "high care." In other words, Kentucky's current nursing facilities are caring for high acuity individuals. These individuals need more assistance with activities of daily living. Some of these residents are admitted to a skilled nursing facility for short- term rehabilitation but, because of their overall health conditions, will require a longer stay beyond the twenty (20) days fully covered by Medicare. Existing providers are currently providing care to the clinically complex and are willing to continue doing so.

Both AFP and the Pegasus Institute claim that current providers are not capable of offering the services that consumers want or need. These claims show a serious lack of understanding of the current post-acute market in Kentucky. Many of the nursing

facilities across the state are in rural counties and are exactly where families and loved ones want them to be - not in the urban-only settings described by Mainstreet. Additionally, for organizations that claim to want to "improve the lives of Kentuckians," they seem to be out of touch with what is happening in Kentucky with regard to the millions of dollars being spent by existing providers to build replacement facilities and renovate existing facilities to provide state of the art, high quality short-term rehabilitation services for Kentuckians. While AFP claims to "champion the free market," its lack of understanding of health care results in doing the exact opposite. KAHCF members welcome competition. However, all competitors should follow the same rules as the current providers and not be given a free government subsidy in order to provide the same exact services that are currently being provided in Kentucky. KAHCF believes that the Commonwealth should invest in Kentucky providers that have invested in Kentucky. The State of Indiana is a prime example as to how uncontrolled growth of skilled nursing services reduces occupancy, which leads to reduced quality and positive resident outcomes as well as increased costs.

2. Bruce Taffer, Carrie Armstrong, Mike Sims, Steven L. Hall, Jennifer Myers, Mary Jo Sprouse, Deann Metcalf, Tori Tiller, Michelle Fellows, Kattie Wheeler, Amy Hicks, Tana Cooper, Darla Sims, Joni Culp, and Beth Harlacher, Superior Care Home, Paducah, KY; Linda Stidham and Connie Wyatt, Parkview Nursing and Rehab, Pikeville, KY; Tom Davis, Diversicare of Nicholasville, Nicholasville, KY; Marilyn Ingram, Countryside Center, Bardwell, KY; Shay Brown, The Klondike Center, Louisville, KY; Melinda Burgard, Hillside Center of Madisonville, Madisonville, KY; Jeffrey Baxley, Owensboro Center, Owensboro, KY; Tevis Tuggle, Landmark of Lancaster Rehabilitation and Nursing Center, Lancaster, KY; and Alecia Stephens, Management Advisors, Inc., provided the following comment:

The amendment to 900 KAR 5:020 is strongly opposed because there is no need for additional short-term rehabilitation services in Kentucky. Current Kentucky licensed nursing facilities and nursing homes are already providing high quality short-term rehabilitation services in their communities and there is no shortage of bed availability.

3. Franklin D. Fitzpatrick, Mountain Manor of Paintsville, Paintsville, KY; Trevor Davis, Homestead Post Acute, Lexington, KY; Stacie Darnold, Gallatin Nursing and Rehab, Warsaw, KY; Mary N. Haynes, Nazareth Home, Louisville, KY; Charlotte C. Thornsberry, Hazard Health and Rehabilitation Center, Hazard, KY; Kimberly B. Nall, Woodland Oaks HCF, Ashland, KY; Elaine Davis, Middlesboro Nursing and Rehabilitation Facility, Middlesboro, KY; Angie Ratliff, Ridgeway Nursing and Rehabilitation, Owingsville, KY; and Tiffany Bryan, Woodland Oaks Health Care Facility, Ashland, KY; commented that the amendment to 900 KAR 5:020 is strongly opposed because this amendment does not represent the current need in post-acute care nor the current trends in establishing better and safe transitions in care across the continuum. In 2007, skilled nursing facilities responded to the need for post-acute care as the acute payment systems changed for partner hospitals disallowing them from providing the short term recovery care. They have worked closely with acute care partners to develop safe transitions and to continue care patterns developed by surgeons with whom they work closely. Their facilities are committed to “recovery to home” care by aligning physicians and advanced nurse practitioners to be on the specialized unit daily and provide therapy seven (7) days

a week. They produce outcomes ahead of national benchmarks, have a low length of stay, and provide value for the Medicare program and its subscribers.

The number of beds available for post-acute care are more than enough in their communities. Due to the global trend of moving to home care as soon as possible, the overall number of people being served in this specialized recovery to home care is declining. They serve individuals with a number of co-morbidities who often require additional stay and care post their Medicare days. The opportunity to have additional care on the same campus for extended recovery is a real advantage for families and allows them to use their Medicare part B services or their qualified Medicaid benefit.

They opposed this amendment based upon lack of need, inconsistency with the current and emerging trends in post-acute care; further silos the challenging health care continuum for Medicare consumers and their families; and it will not produce either a cost saving or an improved outcome in care and is likely to raise costs and damage outcome due to lack of continuity.

4. Angela Goff and Connie Wyatt, Parkview Nursing and Rehab, Pikeville, KY; Tevis Tuggle, Landmark of Lancaster Rehabilitation and Nursing Center, Lancaster, KY; Susan Arnold, Management Advisors, Inc., Hazard, KY; Amelia Prater, Wolfe County Health and Rehabilitation Center, Campton, KY; Teresa L. Kiskaden and Eli Grinspan, Bluegrass Health Partners; Franklin D. Fitzpatrick, Mountain Manor of Paintsville, Paintsville, KY; Janna Shelley, Barbourville Health & Rehabilitation Center, Barbourville, KY; Brad Kennedy, Cardinal Hill Rehabilitation Hospital, Lexington, KY; Maribeth Shelton, Paul Shepard, and Vickie Dyer, Cumberland Valley Manor, Burkesville, KY; Nick Lamkin, Diversicare Healthcare Services, Inc., Brentwood, TN; Cindy Salyers, Diversicare/Boyd Nursing and Rehab Center, Ashland, KY; Kevin Badger, Friendship Health and Rehab, Pewee Valley, KY; Cindy O'Banion, The Grandview Nursing and Rehabilitation Facility, Campbellsville, KY; Jonathan McGuire, Greenwood Nursing and Rehabilitation Center, Bowling Green, KY; Londa Knollman, Brad Stanford, Edward P. Fritz, Michael Hemm, Kelly Simmons, James L. Titus, Gene Weaver, Mark Middendorf, and N. Nick Ziegler, Rosedale Green/Emerald Trace, Elsmere, KY; Stephen D. Wolnitzek, Kenton Housing, Inc., and Wolnitzek, Rowekamp & Demarcus, P.S.C., Covington, KY; Gail Hensley, Harlan Health & Rehabilitation Center, Harlan, KY; Jay H. Trumbo, Health Systems of Kentucky, LLC, Louisville, KY; Gail M. Gibbs, Hillcrest Health & Rehabilitation Center, Corbin, KY; Conjuna Collier, Masonic Home of Shelbyville, Shelbyville, KY; Sarah Fields, Amy Neighbors, Candie Bennett, Carolyn Adwell, Cassandra Brown, Cindy London, Claire Wilson, Cody Brooks, Donna Harris, Jackie Parker, Jimmy Smith, Kandis Gallagher, Kristy Ford, Linda Crenshaw, Rochelle Jones, Eris Smith, and Shelia McCoy, Metcalfe Health Care Center, Edmonton, KY; Bruce K. Duncan, National HealthCare Corporation, Murfreesboro, TN; Missy Bentley, PCPMG Consulting, LLC, Garrison, KY; Donna D. Davis, Princeton Health & Rehab Center, Princeton, KY; Carla Benson, Charlotte Armstrong, Cheryl Forber, Kendall Thomas, Lisa Thompson, Susan Parker, Tammy Tompkins, Tiffany Waymon, and Erin Brown, Redbanks Colonial Terrace, Sebree, KY; Joann Kuhlenschmidt, Randella Robinson, Susan Phipps, and Shari Newton, Redbanks Skilled Nursing Center, Henderson, KY; Jessica Broughton, The Heritage Nursing and Rehab Facility, Corbin, KY; Angie Hamer and Terry Skaggs, Wells Health Systems, Inc., Owensboro, KY, and Board of Directors of the Kentucky

Association of Health Care Facilities; Michelle Jarboe, Williamsburg Health and Rehab, Williamsburg, KY; Beth Arnett, Martin County Health Care Facility, Inez, KY; Stock Longhurst, Louisville East Post Acute; Gail Wilder, Linda Goodman, Jeff Mayes, Christal Woody, Jimmie Carol Prater, Mary Whitaker, Sheron Smith, Sheri Craycraft, Megan Lamont, Monica Johnson, Nancy Corkran, Christy Bean, Meagan Reynolds, Jessica Brock, and Teresa Stout, Middlesboro Nursing and Rehabilitation Facility, Middlesboro, KY; Brittany Hawes, Cathy Froggett, David G. Garst, Faye Hawes, George Prebee, Janet Milby, Jessica Sharpe, Laranda Pendelton, Melissa DeSpain, and Monica Warren, Green Hill Rehabilitation and Care, Greensburg, KY; Angela White, Crystal Delong, Kristina Poole, Shanna Carver, Tracey Cotton, Lonnie Brewer, Brittany Smith, Rita Lewis, Gina McDaniels, Steven D. Patterson, K. Bragg, Kathy Thomas, Stephanie Delong, and S. Simmen, Pam Robinson, Stacie Burton, Ashley Moore, Chelsie Seagraves, CMT; Angie Boremons; Whitney Spears; Johnda Uriel; Cammy Thomas; Kelly R. Clare, SRNA; Joann Smith; Christy L. Viars; Carly; Randall Nimblett, Dietary Aide; Lisa Butem, Dietary Cook; George Thomas; Angie Smallwood; Kayla Necola; Peggy Hamilton, Housekeeping; Bryan Sanders; Kim Baldegh; Jessica William, Dietary Manager; Karen Sturm, Oakmont Manor, Flatwoods, KY; Lori Moberly, Parkview Nursing and Rehabilitation Center/Life care Centers of America, Paducah, KY; Peggy King, Signature HealthCARE, LLC, Louisville, KY; Beverly Satterfield, Cassandra Thompson, Christina Saylor, Heath Payne, Kelly Belcher, Kim Tincher, Rebecca Fernald, Tara Helton, and Tina Harris, The Terrace Nursing Facility, Berea, KY; Anita Lewis, Joy Dingess, Karen Lawson, Pam Hook, and Shelby Richmond Riley, Vanceburg Rehab and Care, Vanceburg, KY; Jenifer Cornwell, Woodland Oaks Health Care Facility, Ashland, KY; Vicki Butler, Diversicare of Greenville, Greenville, KY; Greg Wells, Green Acres Health Care, Mayfield, KY; Brian K. Jaggers, Somerwoods Nursing and Rehabilitation Center, Somerset, KY; Melissa J. Allen, Riverview Health Care Center, Prestonsburg, KY; provided the following comment:

The amendment to 900 KAR 5:020 is strongly opposed because there is no need for additional short-term rehabilitation services in Kentucky. Currently, Kentucky licensed nursing facilities and nursing homes are providing high quality short-term rehabilitation services in their communities. The addition of new short-term rehabilitation beds will siphon off Medicare residents from existing nursing facilities and nursing homes exacerbating the clinical staffing crisis that many providers are experiencing in Kentucky. Kentucky nursing facilities have been providing short-term, post-acute care for many years. These post-acute services occur immediately after discharge from a hospital and are aimed at returning patients to their homes within thirty (30) days, and often sooner. In general, the overall usage and length of stay in nursing facilities is declining. The average occupancy has declined to eighty-seven (87) percent statewide. Space is available in existing nursing facility beds to accommodate the need for short-term post-acute rehabilitation lasting twenty-one (21) days or less. For our nursing facilities to remain viable, existing CON regulations must remain in force and efforts to circumvent long-established rules must be denied.

5. Sally Baxter, Maysville, KY, commented that she strongly opposed the amendments to allow the establishment of new nursing home beds for provision of post-acute rehabilitation services if the proposed annual average length of stay does not exceed twenty-one (21) days. As public policy, this amendment does not represent the

current need in post-acute care nor the current trend in establishing better and safe transitions in care across the continuum. Currently, Kentucky licensed long term care facilities are providing high quality short term rehabilitation. Overall length of stay has declined in most facilities. Census is approximately 87% statewide, so beds are available for short term rehabilitation of less than 21 days. She does not know why the state would consider adding another licensure category. Please keep the existing CON regulations in force so that nursing facilities will remain viable.

6. Charlotte L. Roberts, Bourbon Heights, Inc., Paris, KY, provided the following comment:

The amendment to 900 KAR 5:020 is strongly opposed because there is no need for additional short-term rehabilitation services in Kentucky. Current Kentucky licensed nursing facilities and nursing homes are already providing high quality short-term rehabilitation services in their communities.

7. John Muller, Carespring Healthcare Management, stated that his organization strongly opposed and requests removal of proposed Review Criterion 5. The proposed exception constitutes a government subsidy for those who would endeavor to operate in order to meet this requirement. Buying assets is the free market, buying assets is free enterprise, buying assets is putting capital at risk in order to have the opportunity to do what Carespring does. The proposal of FREE "post-acute 21 day beds" is the most classic example of government subsidization and work around.

Carespring already does what Mainstreet "proposes" as a rapid recovery model. Carespring also serves those in an extended stay as well as those in the last weeks of life. They serve the short term, post-acute patients and nearly sixty-five (65) percent of residents are Medicaid recipients. They have invested millions in their communities and their facilities are economic engines in the communities served. Carespring employs over 800 team members, has payrolls over $25 million, and pays the corresponding taxes that go along with that activity. Throughout their four (4) nursing facilities, 566 skilled nursing facility beds, and one 110 unit Barrington Assisted and Independent Living, Carespring admits and discharges 500 patients per facility (2,000 patients per year); and has an average length of stay for skilled patients of eighteen (18) days (2016). These are the Post-Acute patients. Post-Acute Care can be and is being done.

The many claims made in the testimony regarding health care "quality" in Kentucky are not a reflection of the skilled nursing facility operators nor hospital or physician providers in Kentucky. For example, Mainstreet makes note that only eighteen (18) percent of nursing home providers in Kentucky are 5 STAR. What they fail to disclose (or potentially understand) is the 5 STAR methodology has a forced bell curve, where by design only ten (10) percent of nursing facilities in a state should be 5 STAR while the remaining ninety (90) percent are forced into the 1, 2, 3, or 4 STAR categories. Indeed eighteen (18) percent of facilities that have attained 5 STAR status places Kentucky above the national average. It is off putting, to say the least, that this company is using health statistics that are resultant of generationally life-long challenges here in the Commonwealth. Rather than offer any substantive solution, they only propose to receive a government subsidy to build facilities to serve the most profitable patients. The Cabinet cannot buy in to the proposed cherry picking exception that will ravage the case mix and

reimbursement structure of existing facilities serving all Kentucky residents. Carespring wholeheartedly believes CON can be modernized, but this is not the path.

8. William Covington, Covington's Convalescent Center and Rehab, Hopkinsville, KY, commented that it seemed unusual for a new competitor to join an industry, while dictating the terms of participation, including picking and choosing only the highest reimbursement category of patients as the sole basis for joining the group. Cherry-picking the highest RUG score group as the only participants allowed must raise an eyebrow of those certifying the new provider. Side stepping the certificate of need process from a long established criteria for participation in the providing of long term care services raises enough questions, but wanting only the reimbursement from those paying the highest rate should certainly be resented.

Mr. Covington also stated that Kentucky has roughly 19,000 certified beds in existence that are not fully occupied, so this would be a duplication of services, and would increase the cost to the state to monitor, inspect, and certify new beds. When the initial twenty (20) days are over, where will the remaining eighty (80) days, if needed, be provided? The poor old nursing facility can take over the rehab mid-stream and try to pull together a complete and comprehensive program and plan without the benefit of observing the progress, or lack of it, offered by a different therapy group. Providing these services for up to eighty (80) days may make it difficult to cover the costs while receiving a lessor reimbursement rate and covering all follow-up nursing care, medications, x-rays, and ambulance transportation. Wouldn't that be like being admitted to a hospital for an illness only to be shipped out to another provider regardless of condition, with different doctors, nurses, and a new therapy team, based only on the reimbursement that could be gained during these first twenty (20) days?

This proposal is an attack on the industry itself. If someone wants to provide Medicare therapy, they should get in the program, buy a nursing facility, go through the certificate of need process, comply with the regulations, and compete with the rest of us for all of the reimbursement dollars without picking and choosing the highest rates only.

9. Rick Hendrickson, Dawson Springs City Council, commented that he is a long term care administrator in Webster County and a city councilman in Dawson Springs. He is opposed to the amendment to 900 KAR 5:020 for several reasons. First, the CON process is there for a reason, and has been for some time. In states like Indiana, there has been a dilution of services and supports when the stat allows unlimited growth and start-up. He worked previously for the Indiana Department of Mental Health and knows people that do not like or care for the absence of a safeguard, such as the CON process, as a regulatory tool. Second, aside from all the known issues with this proposed change, his biggest concern is the impact on current facilities and the critical issues of staffing and jobs. The amendment would create devastation for long term care and local economies. Just because it can be done, it doesn't mean it should be done. Third, where do we go from here, if this is passed? When the system is diluted and facilities are jeopardized, what is the state plan for the facilities that will inevitably close and be unavailable to small communities and rural areas? Lastly, this amendment is not needed. As a businessman and long-time human services professional, it is clear that this is another attempt to invade a market that already provides available beds and services. Please do not allow these

professional pied pipers and research groups to hide facts and realities for the known purpose of creating more money for hospitals and practitioners.

10. Elizabeth Townsend and Wanda Meade, Diversicare Management Services, Franklin, TN; Sarah Willis, Diversicare/Wurtland Nursing and Rehabilitation Center, Greenup, KY; Mark Witt, Diversicare/The Highlands Health and Rehab, Louisville, KY; Lindsay Frazier Adams, Diversicare of Fulton, Fulton, KY; Joe Brainard, Carter Nursing and Rehabilitation Center, Grayson, KY; Trella Wilson, Diversicare/Clinton Place, Clinton, KY; commented that they strongly oppose the proposed amendment to 900 KAR 5:020 to allow new nursing home beds for post-acute rehab services by circumventing the current CON process. There is no need for additional short-term rehabilitation beds in Kentucky. Their company has their own therapy team members on staff in their center. They consistently provide high quality short-term rehabilitation service to their patients and residents. Their company has invested millions of dollars to upgrade centers, implement programming, and educate team members to serve this specific short-term patient population. The overall usage of nursing facilities is declining as well as the average occupancy of centers across the Commonwealth. Based on this information, there are many existing nursing facility beds available to accommodate any future need for short-term patients; therefore, rending this proposed amendment a moot point.

11. Jason Gumm, Diversicare of Glasgow, Glasgow, KY, commented that his organization strongly opposed the proposed amendment to 900 KAR 5:020. As public policy, this amendment does not represent the current need in post-acute care nor the current trends in establishing better and safe transitions in care across the continuum. It also goes directly against the intent of the CON process, to be responsible with state resources and with conscientious expansion of health services. The changes allow for circumventing long standing health plan policies that uphold fiscally conservative and prudent use of the state's resources. Their centers' financial viability is directly tied to this post-acute short stay patients that currently access care. It allows centers to function in this environment where their costs aren't covered by the Medicaid portion of reimbursement. Medicaid costs don't even cover fixed costs in their centers.

Additionally, the proposed change creates a new license category that does not have a regulatory component. A facility or provider of this type would not be properly defined within the current state plan. The CON regulation should not be utilized in this way as it is inconsistent with the intent of CON.

In 2007, skilled nursing facilities responded to the need for post-acute care as the acute payment systems changed for partner hospitals disallowing them from providing the short term recovery care. They have worked closely with acute care partners to develop safe transitions and to continue care patterns developed by surgeons with whom they work closely. Their facilities are committed to "recovery to home" care by aligning physicians and advanced nurse practitioners to be on the specialized unit daily and provide therapy seven (7) days a week. They produce outcomes ahead of national benchmarks, have a low length of stay, and provide value for the Medicare program and its subscribers.

His county's occupancy rates do not require this type of drastic measures to provide access to short term rehab. They have the beds needed in their community and

ADD. The need for short term, short stay beds cannot be proven to be across the board in all counties.

He is opposed to this proposed amendment based on lack of need; inconsistency with current and emerging terns in post-acute care; further silos the challenging health care continuum for Medicare consumers and families; will not produce a cost saving or an improved outcome in care and is likely to raise costs and damage outcome due to lack of continuity; and violates the legislative intent of the Kentucky CON law. This amendment does not represent the public policy consideration that must continue to be developed in these economically compressed times.

12. Thomas B. Davis, Diversicare of Nicholasville, Nicholasville, KY, commented that he profoundly opposed the proposed amendment to 900 KAR 5:020. This amendment will allow new nursing facility beds to be built in order to provide post-acute rehab services and not follow the same regulations the current nursing facilities have had to follow for decades. Obviously, with the current Kentucky nursing facility industry already providing this same service, this is nothing more than a duplication of services. If this amendment is allowed, the state will be closing nursing facilities across the Commonwealth as they will no longer be able to operate by only serving Medicaid residents. This amendment will not enhance the health services of those in need of post-acute services and will put thousands of long-term residents at risk. Facilities will not be able to stay afloat with Medicaid long term residents alone.

13. Michael Fielden, Dover Manor, Inc., Georgetown, KY, commented in opposition to the proposed changes to 900 KAR 5:020. He stated that at the public hearing on this administrative regulation on August 21, Mainstreet executives made rather critical statements regarding current long-term care operators in Kentucky. Given those comments and the lofty position taken by Mainstreet, he wanted to provide information about the history of Mainstreet. Mainstreet is headquartered in Carmel, IN, and lists its stock on the Canadian Stock Exchange. In 2016 the company filed a lawsuit against the State of Indiana challenging that state's moratorium on transitional care facilities. An ethics committee investigated the father of the Mainstreet CEO, who resigned from the Indiana House of Representatives following allegations of ethics violations. The company has been plagued with management turnover, with the entire upper management replaced within the last twelve (12) months. It is a Real Estate Investment Trust, specializing in "buying existing senior housing facilities". The Surprise, Arizona, location is not a rapid recovery location, as implied at the public hearing, but will be a 100-bed long term care facility when it is opens, with seventy (70) long term care beds and thirty (30) assisted living beds. CMS data for 2016 indicates a sixty (60) percent occupancy for twenty-six (26) Mainstreet properties in operation as of fiscal year 2015.

The proposed fourteen (14) day discharge of patients would destroy the continuity of care for most elderly patients, potentially resulting in more re-admissions, as well as potentially causing anxiety and disorientation of those patients. Mainstreet executives criticized costs, quality of care, and re-admissions in Kentucky but did not submit cost data, re-admission data, or history of patient outcomes for their company. There are a multitude of negative reviews for Mainstreet on Google, including comments about disruptive leadership; multiple layoffs; lack of direction, focus, and sound leadership. The

Commonwealth needs reliable information from recognized sources rather than allowing itself to be guided by a sales pitch from a company that appears to have a history of misrepresentation.

14. Robert Flatt, Essex Nursing and Rehabilitation Center, Louisville, KY, commented that his facility opposes the proposed amendment to 900 KAR 5:020 because there is no need for a new category of skilled nursing facility (SNF) beds, exempt from full CON review, when an oversupply of those beds already exists across the state. The possibility that new short-term rehabilitation beds will enter the post-acute care landscape without comprehensive CON review is very concerning. Such beds will merely duplicate services already provided by existing SNFs. There is simply no demonstrable evidence that the services offered in this new category of bed will differ in any way, including patient outcomes, from those currently provided by Kentucky's existing SNFs.

The impact of this new category of bed will potentially be catastrophic, as they will strain the operational and financial viability of existing SNFs. Most current SNFs offer a range of services to a range of individuals, and reimbursement for the care provided differs considerably. For example, the care for Medicaid recipients is paid at a much lower rate than Medicare rehab services. Nevertheless, existing licensed SNFs provide the majority of their days of care to the Medicaid population. Creating specialized Medicare-only rehabilitation beds would jeopardize the ability of Medicaid patients to receive care.

The potential consequences of this proposed change could be devastating to Kentucky's senior population. Without a balance of payment sources, existing SNFs likely will not survive. At that point, whose responsibility will it be to ensure access to care for the Medicaid population? The unintended consequences of this proposed change must be recognized and adoption of the amendment should not occur.

15. Steve Brown, Former Member of C.O.N. Board, Glasgow, KY commented that when he served on the C.O.N. Board in the early 1980s, many long-term care providers came before the board to request most beds, with an average occupancy of 98%. The state health care plan did not show a need for more beds so they followed the plan. Many could start to see more short term stays due to patients needing short term rehab. Today, the statewide census is 87%. Long-term care facilities have met the need to take care of short-term post-acute care for many years. He hopes that the C.O.N. Board will see that services are being provided in the correct setting now and not add another layer of cost to a health system that is currently cost-effective. The system is working and patients are receiving high quality rehab and returning home. He asks that the amendments to 900 KAR 5:020 be removed from consideration as the need is being met in a quality setting utilizing short-term beds in KY licensed nursing facilities. Please stick to the plan and let it work as it has now for many years.

16. Darrell Hicks, Hargis and Associates, LLC, Russellville, KY, stated that he opposed the proposed amendment regarding rehab beds. The proposed amendment will increase the number of short-term rehabilitation beds available in Kentucky, which currently has in excess of 18,000 unoccupied beds throughout the state. The additional beds will serve to siphon Medicare residents and revenue from existing facilities. More specifically, the impact of adding short-term rehab beds will increase the Medicaid burden

on the state; negatively impact the significant investments most nursing facilities have made to provide rehab services, exacerbate the nursing and therapy staffing shortage, and eliminate economies of scale benefit from shared payor types. Long-term care facilities have three (3) payor types: Medicaid, Medicare, and private pay. Medicaid and private pay sources along could not financially sustain operations. Opening the CON process will have a detrimental effect on the long term care industry and will ultimately increase the cost to the Medicaid program. In order for nursing facilities to remain viable, existing CON regulations must remain in force and the effort to circumvent long-established rules must be denied.

17. Tammy York, Lake Way Nursing and Rehabilitation Center, Benton, KY, commented that her facility opposes the proposed amendment to 900 KAR 5:020, which is problematic for multiple reasons, including the likely impact it will have on the majority of Kentucky's long-term care population. The specially-designated "post-acute rehabilitation beds" would simply duplicate one (1) of the key services existing SNFs already offer. The result of this change would be an influx of additional SNF beds when there is currently a significant oversupply across the Commonwealth. Furthermore, these beds, although designated as SNF beds, would not actually serve the Medicaid population, which represents the sizable majority of all SNF residents. Fundamental changes to the SNF bed approval and licensure process will only create an unfair playing field for facilities.

18. Timothy L. Veno, LeadingAge Kentucky, Louisville, KY, stated that the membership of LeadingAge Kentucky has strong opposition to the proposed amendment to the State Health Plan to allow the unlimited establishment of Medicare only nursing home beds. The amendment would allow an explosion of new beds where new beds are not needed. With the advent of Medicare and Medicaid, the federal government established payment systems first for hospitals and later for skilled nursing facilities. In order to promote the establishment of these health facilities to provide for access to health care services, the government included reimbursement to help offset the cost of the "bricks and mortar" of these health facilities. In order to preserve the taxpayer investment in the establishment of these health facilities, various states, including Kentucky, enacted Certificate of Need laws.

In Kentucky, the General Assembly passed comprehensive laws intended to prevent the proliferation of unnecessary health care facilities. This includes KRS 216B.010. Oversupply and thus underuse squanders precious taxpayer resources and diminishes overall quality. The proposed amendment is clearly in defiance of the clean and unambiguous language of Kentucky's laws. There is no need for additional nursing home beds. According to the Cabinet's statistics, virtually all Kentucky counties have significantly more capacity, which clearly documents no additional need for those services. The Cabinet's data shows that Kentucky is overbedded by 18,652 LTC beds. This change completely upends years of health planning by blowing a hole in the need methodology for nursing home beds.

This change will create a free-for-all for short stay Medicare beds, which will most likely result in drying up referrals to the existing, free-standing long term care providers. LTC providers are only able to care for the lower reimbursed Medicaid resident by having

diversified payer sources, including Medicare and private revenue. This loss of Medicare revenue will hamper their members' ability to continue to provide services to Kentucky's approximately 24,000 Medicaid residents residing in Kentucky's LTC facilities.

The workforce crisis is particularly acute here in Kentucky. Members are facing major difficulties in recruiting and retaining qualified health care workers. Any explosion of new nursing home beds only increases the health care workforce challenges and diminishes overall quality for everyone.

The LTC industry has created the capacity and competency over the past ten (10) to fifteen (15) years to care for the short stay Medicare resident. Millions of dollars have been invested by existing LTC providers to provide private room accommodations, pleasing modern structures with state-of-the-art care in comfortable homelike environments.

The experts in LTC services were never consulted about one (1) of the most significant changes to CON for nursing homes in the past twenty-five (25) years. To their knowledge, no representative of Kentucky's LTC providers were consulted about these changes. Their members know post acute services better than anybody and it is irresponsible not to consult the experts in the field. Bad public policy is a result of a lack of research and collaboration. Any assertion that has been put forth by mainly out of state companies is nothing more than a bill of goods with the intent to siphon resources from existing providers. It is their hope that this amendment is halted and all stakeholders are assembled to provide feedback and ideas that are more rational than the one proposed.

19. Jay Frances, Legacy Health Services, Inc., Hopkinsville, KY, commented that his organization strongly opposed the proposed amendment to 900 KAR 5:020 because this amendment does not represent the current need in post-acute care nor the current trends in establishing better and safe transitions in care across the continuum. The proposed changes will completely reverse interest in Kentucky from providers who want to come to, or stay in, Kentucky to operate in, create jobs, and invest monies. This would be detrimental to the state and its national reputation as a favorable environment to long term care providers. In 2007, his organization and many other providers of skilled nursing responded to the need for post-acute care as the acute payment systems changed for their partner hospitals, disallowing them from providing short-term recovery care. They have worked closely with acute care partners to develop safe transitions and to continue care patterns developed by surgeons, therapists, and other providers. The committed medical involvement, the seven (7) day a week therapy component, and the additional certification of nurses has enabled them to provide outcomes of national benchmarks, low length of stay, and a value proposition for the Medicare program and its subscribers.

He stated that he opposed this amendment for eight reasons: (1) additional short term rehab beds are not needed, as a 2016 survey indicates Kentucky has 18,653 unutilized beds; (2) there has been no study conducted by the cabinet to validate a need; (3) long term care buildings have been retrofitted to facilitate short term rehab; (4) the proposal is inconsistent with the current and emerging trends in post-acute care; (5) the proposal increases the staffing burdens for nursing and therapy that are already prevalent in many counties to levels never before seen; (6) long term care facilities cannot remain open without a mix of payers – closed facilities will equal loss of jobs, fewer resources for those in need, etc.; (7) adding beds allows for manipulation of the existing payment

system by these new providers; and (8) it will not produce either a cost saving or an improved outcome in care and is likely to raise costs and damage outcome due to lack of continuity.

20. Gary R. Marsh, Masonic Homes of Kentucky, Masonic Homes, KY, commented that he totally opposed the proposed changes to allow adding exclusive post-acute providers. This change was ill conceived, to the determent and without regard for all long term care providers throughout the commonwealth. Nursing homes throughout Kentucky have been serving the post-acute care patients for short term rehab for many years. Skilled nursing facilities depend on these largely Medicare A patients to help offset the significant shortfall for providing for Medicaid residents. Furthermore, many of the patients admitted to short term become long term residents. What would a totally short term provider do with a resident needing a longer stay? It would not be wise to uproot them to another facility for extended care. It cannot be overstated the determent to the long term care industry that stepped to the plate to provide quality short term care and rehabilitation for this change to negatively affect so many for an unnecessary change. With potentially significant changes and cuts to the Medicaid budget by the federal government, this would be a double whammy that could make long and short term care unavailable to the citizens of the commonwealth.

21. Debra Finneran, Sam Swope Care Center, Masonic Homes of Kentucky, Masonic Homes, KY, commented that her organization opposed the amendment to the current CON language in 900 KAR 5:020 to allow the establishment of new nursing home beds for the provision of post-acute rehabilitation services, if the proposed annual average length of stay does not exceed twenty-one (21) days. The Masonic Homes provide and coordinate quality driven health outcomes in a cost effective, community based model that is focused on resident safety and reduction in re-hospitalization. There is not a need for additional skilled beds for short term rehabilitation. This proposed amendment will allow the creation of a health model in which the patient will be channeled into an inclusive, controlled service system designed to benefit few and eliminate competitive options for the patient. If Kentucky is to have a health service model that is sustainable, competitive, and quality outcome driven, we need to support expansion models that do not duplicate viable, existing health services and do not create a system that eliminates patient care option. Kentucky's existing continuum of care system may not be perfect but it serves our communities well, providing necessary access to cost effective local services and providing jobs, benefits, and taxes that support the community at large.

22. Cortney Burkhart, Maysville Nursing and Rehabilitation Facility, Maysville, KY, commented that she is strongly opposed to the proposed amendment to 900 KAR 5:020 regarding post-acute rehabilitation beds. As public policy, this amendment does not represent the current need in post-acute care nor the current trend in establishing better and safe transitions in care across the continuum. Her nursing home and others responded to the need for post-acute care as the acute payment systems changed for partner hospitals disallowing them from providing the short term recovery care. They have worked closely with local hospitals to develop safe transitions and this has allowed them to produce outcomes ahead of national benchmarks. It is vital that existing CON

regulations remain in effect and efforts to circumvent established rules must be denied.

23. Melissa Robbins, Middlesboro Nursing and Rehabilitation Facility, Middlesboro, KY, commented that she has fervid opposition to the amendment for 900 KAR 5:020 regarding post-acute rehabilitation services. A change in the current CON policy is not needed in the current post-acute care environment in Kentucky. Additionally, adding additional nursing facility beds will not improve safe transitions across the continuum of care. It would be more beneficial to support the currently established nursing facilities in providing safe patient transitions rather than add unneeded beds, which will floor the post-acute care market and cause undue hardship on current providers.

Several of their post-acute care residents have been offered the choice to remain in the hospital using their Medicare post-acute care benefit in a "swing bed". Most decline this offer because they do not want to stay in a hospital environment for twenty (20) days, which puts them at an increased risk for negative outcomes such as hospital acquired infections. Residents who spend their first twenty (20) days in a hospital sing bed are in greater need when they are discharged to her facility on day twenty-one (21). Hospitals are not meant or equipped to provide post-acute care to a population with multiple co-morbidities. Skilled nursing facilities are specialized in providing care to this population. They understand what it takes to care for the whole patient and not just acute illness. including the plethora of medical and social needs of each post-acute care resident. Patients and families choose her facility to recover closer to home in a nonclinical environment. Also, in her small community, residents' families cannot afford to travel hours to visit loved ones for weeks at a time. The facility staff provides topnotch post-acute care close to home and families feel assured that their loved ones are in the capable hands of those with numerous years of combined expert experience in post-acute care. This is the same experience that has proven time and again that choosing care in a skilled nursing facility is the right choice for Kentuckian's post-acute care needs.

In 2007, skilled nursing facilities responded to the need for hospitals to discharge their patients to post-acute care for short term recovery before returning home. Since that time, skilled nursing facilities across Kentucky have been working diligently to provide superior care to those in need following an acute illness. Her facility works closely with their local hospital and those in metropolitan areas to bridge the care gap between hospital and home. Facility staff is committed to seeing patients succeed in their rehabilitation goals by providing expert medical care and exemplary therapy seven (7) days per week. They work with home health and DME agencies to provide successful discharges to the community for post-acute care patients. Additionally, if additional care is needed following a Medicare benefit period, especially for patients with multiple co-morbidities, the care is readily available. Patients can be seamlessly transitioned from one (1) level of care to another without leaving the facility campus. Thus, the patient does not need to move to a new environment where medical and social needs are unknown. Transitioning care poses a new and unnecessary threat to the patient by way of omitted details about the patient's specific needs. If post-acute care is provided in units that can only provide care for twenty (20) days, these very ill patients will have to be transitioned again, likely to a skilled nursing facility for additional services.

She is vehemently opposed to this amendments for the following reasons. There is not a need for more post-acute care beds in the current continuum of care. Adding

additional beds is not going to make transitions safer for those requiring post-acute care in Kentucky. Legislative time and energy would be better spent on promulgating a way to assist its population in receiving services for safe and healthy transitions to the community following a stay at a skilled nursing facility. Many patients return home without the supports they need to stay healthy due to lack of funding to much needed community support systems. Lastly, this amendment will not produce a cost savings or improve patient outcomes; it will raise costs because it will interrupt the continuum of care and increase the risk to those in need of post-acute care.

This amendment does not represent the policy that will help to develop the economy of Kentucky in these economically depressed times. This policy will help to eliminate jobs in depressed rural areas by decreasing the census of skilled nursing facilities. In some communities, nursing facilities are one of the largest employers. This policy will limit access to local skilled nursing facilities by forcing the downsizing of available beds.

24. Vivian Lambert, Mountain View Nursing and Rehabilitation Center, Pineville, KY, stated that her facility wholeheartedly opposed the proposed amendment to create small rehab-only skilled nursing facilities (or units) largely outside the CON process. The provision of SNF care is challenging as facilities deal with a very sick and vulnerable population. Existing Kentucky SNFs serve residents of a variety of payer sources, particularly Medicaid. These newly-designated SNF beds would be only for short-term rehab patients, for fewer than twenty-one (21) days. These individuals would by and large be Medicare beneficiaries. As opposed to Medicaid, Medicare reimburses at a much higher rate. Therefore, these specialty SNF-beds/facilities/operators will only be admitting higher-paying Medicare patients. There is no evidence that these types of providers produce better results than SNFs so it is unclear what benefit there would be to Kentucky and its elderly population.

There is a very real risk of dismantling the already tenuous existing SNF system, which works by balancing a multitude of payers. With a reduction in current SNF supply, which could happen as a result of these newly-designated beds, care options for Medicaid patients would be greatly diminished. With an already existing supply of empty SNF beds that can provide the very same services, the approval of the proposed amendment would make no sense.

25. Mark Millet, Pine Meadows Post-Acute, Lexington, KY, commented that he strongly opposed the amendment to 900 KAR 5:020 regarding post-acute rehabilitation services. His facility averages ninety-five (95) percent occupancy and serves twenty (20) to twenty-five (25) rehabilitation patients daily, with capacity to accommodate an additional five (5) patients. As public policy, this amendment does not represent the current need in post-acute care nor the current trend in establishing better and safe transitions in care across the continuum. The number of beds available for post-acute care are more than enough in his community. Due to the global trend of moving to home care as soon as possible, the overall number of people being served in this specialized recovery to home care is declining. They serve individuals with a number of co-morbidities who often require additional stay and care post their Medicare days. The opportunity to have additional care on the same campus for extended recovery is a real advantage for

families and allows them to use their Medicare part B services or their qualified Medicaid benefit. Their partner hospitals rely on their ability to work with patients and families whose needs emerge during the transition period.

He opposed this amendment based upon lack of need, inconsistency with the current and emerging trends in post-acute care; further silos the challenging health care continuum for Medicare consumers and their families; and it will not produce either a cost saving or an improved outcome in care and is likely to raise costs and damage outcome due to lack of continuity. This amendment does not represent the public policy consideration that must continue to be developed in these economically compressed times.

26. Michael Bowlden, Richwood Nursing and Rehab, LaGrange, KY, commented that he strongly opposed the amendment to 900 KAR 5:020 regarding post-acute rehabilitation services. As public policy, this amendment does not represent the current need in post-acute care not the current trends in establishing better and safe transitions in care across the continuum. His facility has 120 beds certified for Medicare and Medicaid patients; in the past, they served twenty-five (25) to thirty (30) Medicare short-term rehabilitative patients at any given time, but the current average is closer to eight (8). The reason for the change is because new, hospitality style facilities have been built in close proximity to them. Their closest hospital also converted hospital beds to skilled short term rehabilitative beds. There are more beds than needed for this type of care in his community. The new facilities cannot reach full capacity because of the emphasis and desire for individuals to return home for home health care. His facility works closely with hospital partners and communicates with physicians and nurse practitioners daily. Their facility's length of stay is currently 19.5 days for short term rehab patients. Let the owners and investors of these developments find their beds within the current healthcare community. Many of the developers are out-of-state businessman who only are concerned with investment dollars and not Kentucky citizens.

He is opposed to this amendment based upon lack of need, inconsistency with the current and emerging trends in post-acute care; further silos the challenging health care continuum for Medicare consumers and their families; it will not produce either a cost saving or an improved outcome in care and is likely to raise costs and damage outcome due to lack of continuity; and out-of-state businessmen are only interested in their dollars. We need people to invest in Kentucky because that will be good for our citizens. This amendment does not represent the public policy consideration that must continue to be developed in these economically compressed times.

27. Jackie Carlin, Rivers Edge Nursing and Rehabilitation Center, Prospect, KY, stated that her facility strongly opposed the proposed amendment. The new category of skilled nursing facility beds is unneeded in Kentucky. There are already many underutilized SNF beds in the state's inventory, beds that are readily available to serve the population targeted by this proposed amendment. Furthermore, existing SNFs, which serve a broad spectrum of Kentucky's elderly population, will be unfairly disadvantaged.

The unintended consequences of authorizing the proposed amendments are potentially harmful to the state's elderly population. New boutique rehab-only SNFs will not serve the vulnerable Medicaid patients, instead targeting the higher-reimbursing

Medicare population. Facilities rely on a mixture of payers to operate efficiently, a model that will be greatly disrupted by the proposed change. Will facilities like Rivers Edge, which have served their communities for years, be able to survive?

The state's CON program exists, in part, to ensure that there is not an oversupply of healthcare services, including SNF beds. This proposed amendment completely contradicts that purpose while simultaneously disadvantaging existing providers, and the very population for which the CON law exists to ensure access to care. Moving forward with this amendment will not benefit Kentucky.

28. Linda McConnell, Robertson County Health Care Facility, Mt. Olivet, KY, commented that she opposed the amendment to 900 KAR 5:020 because it seeks to remedy a problem that does not exist. It is not consistent with current trends in establishing better and safe transitions in care across the continuum. Her facility has been serving the local community and surrounding counties since 1992. They have developed programs consistent with the care needs for short-term rehabilitation. They diligently work in collaboration with local hospitals and physicians to assure they are meeting current trends of need. They are very successful in providing for the needs of the residents, both short-term (less than twenty (20) days) or rehabilitation requiring more than twenty (20) days. Each part of the CON in Kentucky directly affects another.

29. Jeff Stidam, Signature HealthCARE LLC, stated that he opposed the proposed amendment regarding rehab beds. There is a great deal at stake here from the proposed CON changes that do not address the true need but shift one (1) specific funding stream, a stream that providers need, without addressing the real, fundamental changes needed to maintain safe transitions in care across the continuum.

The challenges faced with these changes include: lack of need; inconsistency with current and emerging terns in post-acute care; further silos the challenging health care continuum for Medicare consumers and families; and will not produce a cost saving or an improved outcome in care and is likely to raise costs and damage outcome due to lack of continuity. This amendment does not represent the public policy consideration that he can support.

30. Stephanie Lindsey, Signature Healthcare of Bowling Green, Bowling Green, KY, commented that she opposed the potential for new transitional care because it is not needed in Kentucky. Many nursing homes have plenty of open beds to fulfill any increase in need for care. Hospitals wanting to take on this care are not familiar with skilled care regulations. For instance, hospitals are allowed to use physical and chemical restraints but nursing facilities avoid them. Nursing homes try to provide a very homelike atmosphere and fill the day with purposeful activities, including having regularly-scheduled volunteers to sing, play music, and other activities. The residents in a transitional facility would not have access to a strong quality of life program or regular volunteers. A transitional facility would deeply hurt many nursing facilities because they depend on Medicare dollars to stay open and pay bills. There are staffing shortages around the state and this proposal would make it even more difficult for residents to receive needed quality care.

31. Kathy E. Gallin, Signature HealthCARE Consulting Services, LLC, Louisville, KY, commented that Criterion #5, regarding the post-acute rehabilitation services, should be removed from the State Health Plan until a further review is studied as to the immediate impact, along with a further analysis of statewide population health needs in order to put together a comprehensive strategic plan involving SNFs, hospitals, patient care needs including mental health specialization and the healthcare ecosystem as a whole, not as a singular one-off insert which could leave vulnerable Kentuckians without care and a place to live overnight..

The current State Health Plan provisions would have a negative impact to the care they give and possibly the economic demise of the long-term profession as a whole. The proposed amendment shifts one specific funding stream, which is desperately needed by post-acute care providers, to acute hospital providers or others, without addressing the real, fundamental change needed.

Mainstreet has requested a “carve-out” to the existing CON law in order to care for this post-acute patient (non dual-eligible), asking not to be subject to the same certificate of need license restrictions that the industry has been under since 1972. Not only would this be an economic disaster to an already underfunded healthcare sector, but the state is over-bedded as it is according to the 2016 data from the Office of Health Policy (CHFS) by 18,865. Moreover, claims by the Pegasus Institute and Americans for Prosperity that Kentucky hospitals face higher penalties is a small microcosm of the sector, and can be addressed through on-going hospital-SNF partnership development, and investing in the already dual-eligible underutilized beds in 119 of the 120 counties. Mainstreet stated they serve the Medicaid population, but when questioned by the H&W committee, admitted they do have Medicaid certified beds but openly said they do not use them, thereby implying they only will take Medicare patients and are “cherry picking” the post-acute short term rehab market. They purport to have a 90% occupancy rate, but documentation could not be found to support that statement.

Mainstreet as part of their clinical excellence model states they will have physicians at properties daily, full time therapists, and acute care nursing to create a competitive advantage of post-acute providers and to enable treatment of more disease pathways than a traditional skilled nursing facility. Signature HealthCARE is also a post-acute provider, investing millions for best customer experience and rehabilitation. They are doing nothing that we and other providers are not already doing.

Signature HealthCARE welcomes Mainstreet’s competitive entrance to the state, but are merely asking that they “apply” for certificate of need based on market based and chronic disease data in the same way Signature HealthCARE does because of the over-bedded/under-utilized conditions in the state currently at 18,865, which would also require Mainstreet to admit the dual eligible patient, i.e. Medicaid patient into their model and take care of the full capacity those who need rehab services, AND the long-term care elderly resident.

They estimate that 2,566 short term Medicare rehab residents would be lost in one year for SHC KY facilities under this scenario, an apple to apple of Medicare only patients. These lost residents would result in a $23.1M revenue reduction, $9.5M EBITDA reduction, and 141 ADC (avg. daily census) reduction.

Changing CON rules to allow free-standing Medicare post-acute transitional units will severely destabilize skilled nursing facilities in Kentucky

Signature HealthCARE concluded their comments by stating: "While the CON system does have its flaws, we ardently ask for repeal of provision #5 in the current suggested state plan amendment comments until more collaborative dialogue is considered for real solutions to evolve based on current demographics, chronic care needs, Kentucky's growing health crisis including the opioid epidemic and other mental health considerations, an overall health population management review—and in summary, the real care needs from an analytical perspective and not just a didactic and anecdotal free for all. … we believe it will require more information before this newest provision can be enacted as it stands currently and ask that the language be removed for vetting and further intentional deliberation."

32. George Burkley, Chief Strategy Officer for Signature HealthCARE, commented at the public hearing. Mr. Burkley commented that Signature operates 125 skilled nursing facilities with 22,000 employees in 11 states and is the "largest operator in terms of just facility numbers" in Kentucky. Signature operates facilities in 85 or 86 counties in Kentucky and has "invested heavily" and "grown" in Kentucky over the last two or three years. They have "invested tens of millions of dollars in the facilities that we own and operate in this state and have really committed as an organization to the state to address the significant needs in post-acute care for the citizens of Kentucky." Mr. Burkley agreed with those in favor of the proposed revision in that "change is needed" but disagreed with the proposed revision's "extracting one small portion of the population that frankly has a much more favorable funding stream in our sector than every other individual being served…this is not the way to address the larger, comprehensive, complex issue of caring for folks from before they go to a hospital through the full continuum to home and then keeping them healthy and out of frankly the health care system… It does nothing to drive efficiency into the health care system. All it does is isolate a population to drive funding into one pool that actually will increase overall cost of care… the post-acute skilled nursing sector is in an extreme state of change today and we all know it… within the skilled space or the skilled nursing facility space, we have approximately 80% of our patient population… that the national data shows we lose money on. The cost of care is greater than what we're reimbursed." Mr. Burkley concluded by requesting "that the CON language as proposed not be advanced."

33. Dianne Timmering with Signature HealthCARE commented that her organization is "opposed to this State Plan amendment provision as it is written." Ms. Timmering commented: "Yes, we're trying to protect the consumer, but this is not an effort for protectionism. We also welcome the Governor and the new Cabinet and a lot of the free enterprise… but there are available CONs, as many have so eruditely said, including my colleagues George and Terry Skaggs. We welcome the competition. Come in. Buy the CON's…."

34. Billie Hurst, Somerset Nursing and Rehabilitation Facility, Somerset, KY, commented that she opposed the amendment to 900 KAR 5:020 because there is not a need for additional short-term rehabilitation services in Kentucky. The addition of short-term rehabilitation beds will cut off Medicare residents from existing nursing facilities and nursing homes. Kentucky nursing facilities have been providing short-term, post-acute

care for many years. Overall usage of nursing facilities is declining. Length of stay has declined. The average occupancy in the Commonwealth has declined to 87% statewide. Space is available all over the state at existing nursing facilities. This proposed amendment is not necessary and she strongly opposes it.

35. Jerree Humphrey and Linda Rubarts, Somerset Nursing and Rehabilitation Facility, Somerset, KY, commented that they strongly oppose the amendment to 900 KAR 5:020. They work closely with acute care partners, surgeons, and families to develop transitions and continuity of care. They have and continue to provide high quality short term care to their community, which includes a seven (7) day a week therapy component. Their goal is a short term stay of thirty (30) days or less. Acute care settings lack a one-on-one patient relationship; long term care facilities specialize in providing a personal caring atmosphere there improves health and speeds recovery. This allows them to give patients the best possible outcome while implementing short-term rehabilitation. Their facility provides a beautiful newly constructed rehabilitation unit, including private suite like rooms, personal high end bathrooms, personal phones, cable TV, Wi-Fi, a fully functioning kitchen in the therapy gym, and a private dining room in the unit. The therapy gym is fully equipped with the latest ACP Accelerated Care Plus Equipment, including a Diathermy machine, ultrasound, omni-cycle, and synchrony. Their PT, OT, and ST programs include a highly trained and committed set of therapists and techs who receive ongoing education in their specific fields, including the ACP equipment. Their patients and families rely on them as a partner in recovery. They are opposed to this administrative regulation based on the lack of need, the inconsistent care that would be provided when merging acute care with long term care needs, and the possibility of cost increase.

36. Vanessa Hines, Somerset Nursing and Rehabilitation Facility, Somerset, KY, commented that her facility strongly opposed the amendment to 900 KAR 5:020 because there is no need for additional short-term rehabilitation services in Kentucky. Currently, Kentucky licensed nursing facilities and nursing homes are providing high quality short-term rehabilitation services in their communities. The addition of new short-term rehabilitation beds will siphon off Medicare residents from existing nursing facilities and nursing homes exacerbating the clinical staffing crisis that many providers are experiencing in Kentucky. Kentucky nursing facilities have been providing short-term, post-acute care for many years. These post-acute services occur immediately after discharge from a hospital and are aimed at returning patients to their homes within 30 days, and often sooner. In general, the overall usage and length of stay in nursing facilities is declining. The average occupancy has declined to 87% statewide. Space is available in existing nursing facility beds to accommodate the need for short-term post-acute rehabilitation lasting 21 days or less. For our nursing facilities to remain viable, existing CON regulations must remain in force and efforts to circumvent long-established rules must be denied. She also stated that she is opposed to this amendment based upon: lack of need; inconsistency with the current and emerging trends in post-acute care; further silos the challenging health care continuum for Medicare consumers and their families; and will not produce either a cost saving or an improved outcome in case and is likely to raise costs and damage outcome due to lack of continuity. This amendment does not represent the sort of public policy consideration that must continue to be developed

in these economically compressed times.

37. Jennifer Davis, Somerset Nursing and Rehabilitation Facility, Somerset, KY, commented that she strongly opposes the amendment to 900 KAR 5:020 regarding the post-acute rehabilitation beds. She does not believe there is a need for additional short-term rehabilitation services in Kentucky. Her facility has provided high quality short term rehabilitation care for many years, with the goal of returning patients home in thirty (30) days. Many times residents return home even soon. Overall, occupancy in nursing facilities is down in our state overall so there is no shortage of beds.

In addition, the organizations that are advocating for this change have stated that patients wish to access rehab services in newly constructed concierge hotel-like settings. Her facility includes a newly constructed rehabilitation wing with private rooms, as do many other facilities like her own. They provide therapy seven (7) days a week. Their short-term rehabilitation suites include complimentary phones, cable television, and Wi-Fi, giving the facility a hotel-like appearance to residents. The proposed amendment is not necessary and she strongly opposes it.

38. Stuart Locke, Southern Kentucky Rehabilitation Hospital, Bowling Green, KY, commented that he supports and agrees with much of the position expressed by the comments submitted by the Kentucky Hospital Association. However, he has a differing position on the subject of Post Acute Care in Kentucky.

The Nursing Home Compare system established by CMS is a good system in that it alerts potential consumers as to the opinions of others who have utilized prior services. However, to say that anyone who is rated a “4” or “5” star provides sub-standard care is not a position he shares with KHA.

Additionally, the document states that it takes weeks or months to place patients in Skilled Nursing Facilities, but that is not a situation that is experienced at Southern Kentucky Rehab Hospital. Upwards of seventy (70) percent of their patients discharge to the home setting, but they do have some who are able to achieve high enough goals to go home safely and need some time in Skilled Nursing Facilities. When this occurs, they are able to place these patients typically within a couple of days, sometimes the same day. They do not experience situations where it takes multiple weeks or months to place patients, simple or complex. There are ample number of both skilled beds and long term care beds available and accessible.

He does not support the needs for Acute Care Hospitals to be able to establish Transitional Care Units for those reasons cited. There are many post acute beds available in the Inpatient Acute Rehab Hospital setting that can serve as a true rehab transition. If these services are utilized, the need for longer term beds will decrease further as more than seventy (70) percent of these patients transition to home after discharge. For those that need additional supervised care in a Skilled Nursing Facility, placement can be made with a matter of a very few days, usually as a result of increased function and decreased dependence following the intensive rehab at the Inpatient Rehab Facility.

39. Sandra J. Dick, Spring Creek Health Care, Murray, KY, commented that Spring Creek Health Care has been providing short term, post-acute care for residents in their community for over fifty (50) years. The past two (2) years, over 200 individuals have

returned to their homes or a lesser level of care from their short term rehab area. Her census is at an all-time low of 126. The Western Kentucky area facilities have beds available and their missing is to provide rehab services. If the certificate of need process requirements change, it will devastate her livelihood. The struggle with census remains with the facility's owner, Murray Hospital. If other businesses come to this area, they will take the short term rehab residents. Please consider the harm that will come to this facility and others located around them that also have census challenges. There is not a need for additional short term rehabilitation services in Kentucky.

40. Hattie Helton and Lois Phipps, The Heritage Long Term Care and Rehabilitation Facility, Corbin, KY, commented that they strongly oppose the proposed amendment to 900 KAR 5:020. There is no need for additional short-term rehabilitation services in Kentucky. There is a decline with referrals; the proposed amendment will cause the overall usage of nursing facilities to continue to decline and will cause crisis to many nursing providers. Due to the decline in referrals, it is hard to keep the beds census up with rehab units at present. Kentucky nursing facilities have been providing short-term, post-acute care for many years and for nursing facilities to remain viable, the existing CON regulations must remain in force.

41. Donna Cawood and Kimberly Bray, The Heritage Nursing and Rehab Facility, Corbin, KY, commented that she opposed the amendment to 900 KAR 5:020 because there really is no need for more short-term rehab beds in Kentucky. Her facility receives very few rehab only referrals; they mostly receive long term residents. The facility had a successful "rehab" unit until about a year ago. Due to reimbursement rates, hospitals are finding ways to beat the system. It hurts the true rehab facility and, most importantly, the patient who needs the appropriate and best rehab care. Hospitals are hospitals. Rehab units are more comfortable and home like, which increases the overall rehab experience. Ms. Cawood stated that she wishes the legislators could talk with rehab residents and get their opinions. They both stated that this proposal would damage long-term care and cause currently good operating rehab units to suffer.

42. Mike Wideman, and Lavinia O'Connor, Treyton Oak Towers, Louisville, KY, commented that he strongly opposes the amendment for 900 KAR 5:020. There is no need for additional short-term rehabilitation services in Kentucky. Currently, Kentucky licensed nursing facilities are providing high quality short-term rehabilitation services in their communities. Their viability has and remains dependent upon meeting or exceeding consumer expectations, Medicare, managed care, and other payer sources quality metrics. In spite of meeting those expectations, thousands of skilled nursing beds are currently empty across Kentucky.

Kentucky nursing facilities have experienced a twenty-seven (27) percent decline in occupancy over the past two (2) years. Advances in medicine, payer source demands, and consumer expectations all contribute to the reduced utilization of skilled nursing services. Those that do use skilled nursing services more often than not have complex medical conditions and fragile support systems necessitating a skilled nursing stay that often times becomes a long term stay. Additional skilled nursing beds will duplicate what is already provided and siphon off from an already reduced number of Medicare recipients

needing skilled care. For our nursing facilities to remain viable, existing CON regulations must remain in force and efforts to circumvent long-established rules must be denied.

43. Chris Maddox, Treyton Oak Towers, Louisville, KY, commented that he strongly disagrees with the amendment for 900 KAR 5:020. The proposed changes may seem that they have merit on the surface, but this is a company trying to usurp privileges previously reserved for facilities that have fought long and hard to abide by every aspect of Kentucky state and federal laws. A specific company is trying to go around these laws set forth over many years of legislation by proposing amendments that only they will benefit from. This is a smart business play by them but will indeed harm the healthcare industry as a whole in Kentucky.

Competition is definitely a good thing for the residents of Kentucky's facilities, because it makes all strive to be the best, provide the best care services, while investing in resident's living quarters and employees. We must surpass the expectations of residents and insurance companies to remain a viable company. However, when someone wants to not abide by the same set of rules, it is not good for the industry as a whole nor the resident population as a whole.

We do not need additional short-term rehabilitation services in Kentucky. For many reasons, there are thousands of skilled nursing beds empty statewide, with a collective twenty-seven (27) percent decline in occupancy over the past two (2) years. Already we have seen competitor facilities closing in the Louisville market because there is too much competition for the skilled and long-term patient load of the city. This is the same situation across Kentucky. As the number of available beds go up and the patient load drops, it makes it very difficult for facilities to maintain affording to provide the needed quality care that residents deserve. Most of the skilled nursing care residents need a high level of care due to the complexity of conditions and the advances in medicine that require highly trained professionals. These complexities often lead to the need for long-term care. Adding more nursing beds will be detrimental to some established nursing facilities and harm many more. To remain viable, Kentucky nursing facilities need the Cabinet to stand by existing CON regulations and deny any circumventing of these rules.

44. Jeff Wilder, Tri-Cities Nursing and Rehabilitation Center, Cumberland, KY, stated that he opposed the proposed amendment because it will not benefit the elderly citizens of Kentucky. Introducing a new type of skilled nursing facility (SNF) bed that is effectively exempt from full CON review effectively contravenes the purpose of the CON program in Kentucky. New beds will be added, thereby unnecessarily duplicating a service for which there is already an oversupply. Furthermore, these new beds, as operated by the main proponent of this change, would likely not accommodate Medicaid recipients, who represent the largest proportion of SNF residents.

Why add beds to a system with declining censuses and that will detract from the ability of existing, proven operators to operate effectively and efficiently. SNFs provide the same short-term rehabilitation services contemplated by this amendment. There simply is not a need for a different classification of SNF beds to serve the rehab population.

45. Randall J. Bufford and Kathy Corbin, Trilogy Health Services, LLC, Louisville,

KY, commented that Trilogy Health Services, LLC, commented that he strenuously objects to the proposed addition of 900 KAR 5:020, Section III(A.)5., regarding rehabilitation beds. Over the last ten (10) years, Trilogy has invested hundreds of millions of dollars in new construction of skilled nursing facilities and replaced outdated physical plants with new centers, specifically designed to provide a modern, homelike environment while enhancing individual's quality of care and quality of experience. Additionally, they have identified locations within counties that are more accessible to growth patterns and easily reachable via the city's infrastructure and relocated facilities there when prudent. They have consciously downsized facilities and moved beds to multiple locations within the same county to meet resident needs. Based on its history and experience, Trilogy strenuously objects to 900 KAR 5:020's amendment.

First, the proposed language violates KRS Chapters 216B and 13A. The stated purpose of the certificate of need statute is to prevent the proliferation of unnecessary health-care facilities. The Cabinet's own need methodology shows that the state has 18,653 too many nursing facility beds. The facilities already providing nursing facility care offer post-acute rehabilitation services and are ready, willing, and able to continue doing so. KRS 216B.010 further recognizes that unnecessary duplication increases costs and results in underutilization of existing services. The Cabinet cannot simply ignore the purpose of the governing statute, exceed its statutory authority, disregard its own need methodology, and develop policy in violation of KRS Chapter 13A.

Additionally, it is unsound public policy and encourages cherry picking. Developing a plethora of Medicare only facilities limiting stays to twenty-one (21) days will not enhance quality or accessibility for anyone needing post-acute rehabilitation services. What will result is underutilization of the existing infrastructure, which serves all payor sources and accommodates all lengths of stay. There is no reasoning, logic, or benefit to this proposed change. Existing options are available in every county. Kentucky already has privately owned, publicly traded, for profit, not for profit, single providers, and large and regional chains to choose from when seeking services.

The provision of long-term care has changed dramatically over the course of several years. Providers have mandatory reporting, quality measures, and documentation standards to which they must adhere. Doing so requires the investment of substantial resources that, in turn, results in an expertise in solving problems and achieving results for the individuals they serve. The proposed State Health Plan expansion threatens the viability of existing providers and will erode quality with no benefit to consumers. Paragraph 5 of the proposed amendment should be deleted.

The better solution to addressing any consumer needs is the provision in Section III., Long Term Care A., Nursing Facility Beds Review Criteria, #3. This provision allows the transfer and relocation of CON approved beds within an area development district or contiguous county. This approach allows appropriate utilization of existing resources and is sound planning and public policy.

(b) Response: The Cabinet appreciates the comments regarding the Post-Acute Rehabilitation Beds. The Cabinet will amend the State Health Plan in response to these comments. Specifically, the Cabinet will amend the Review Criterion #5 to establish a Post-Acute Transitional Care Pilot Program. The Cabinet recognizes that Kentucky ranks forty-ninth (49th) out of the fifty (50) states in hospital readmission rates, which creates a

financial burden for hospitals located in the Commonwealth of Kentucky. The pilot program will address Kentucky's high hospital readmission rates pursuant to this criterion 5. The new criterion authorizes no more than a total of four (4) applications, with up to two (2) located in a rural Core Based Statistical Area (CBSA) and up to two (2) located in an urban CBSA, to establish nursing facility beds in a freestanding facility or as part of an existing facility if the applicant satisfies all other requirements of certificate of need, including the formal review, and demonstrates: the annual average length of stay for the proposed nursing facility beds shall not exceed twenty-one (21) days; readmission rates for hospitals discharging patients to the proposed nursing facility beds will decrease; seventy-five (75) percent or more of patients discharged from the proposed nursing facility beds will transition to a home or community based setting; and the applicant agrees to submit an annual report on the average length of stay within their nursing facility beds, hospital readmission rates, and discharge settings to the Cabinet for Health and Family Services.

Additionally, in the Need Assessment for Nursing Facility Beds formula, the Cabinet will specify that the calculation for "C", which is the average number of empty beds in the county of application and all Kentucky counties contiguous to the county of application, shall not include nursing facility beds approved pursuant to the Post-Acute Transitional Care Pilot Program.

Kentucky has gained national recognition for poor quality long term care and this criterion provides a new setting to enable patient choice within the spectrum of care. It is important to note that the criterion is not limited to rapid recovery centers, but the criterion has inclusive language, enabling the criterion to be met by hospitals, skilled nursing facilities, and new facilities.

Nursing home beds approved under this criteria (III. Long-Term Care; A. Nursing Facility Beds; Review Criteria, #5) will be included in the State Health Plan and are subject to the formal review process. A Certificate of Need will still be required. The formal review process requires a five (5) prong analysis established by KRS 216B.040(2)(a)2., which includes (1) consistency with the State Health Plan; (2) need and accessibility; (3) interrelationships and linkages; (4) costs, economic feasibility, and resources availability; and (5) quality of services. Review Criterion #5 enables an application to establish nursing home beds for the provision of post-acute rehabilitation services to meet the first prong, consistency with the State Health Plan, if the requirements of the pilot program are met. The applicant has the burden to demonstrate that the application should be approved.

(8) Subject: Home Health Care

(a) Comment: Comments regarding the changes in the State Health Plan regarding Home Health Care were received from many organizations, providers, and citizens. The comments can be grouped in four subtopics: general comments about the Review Criteria, comments requesting an amendment to Review Criterion #4, comments in support of the deletion of previous Review Criterion #6, and comments in opposition to the deletion of previous Review Criterion #6. Because the responses to each subtopic are interconnected, the ten (10) comments about Home Health Care are included and summarized as part of this comment. (This comment relates to "III. Long-Term Care; B. Home Health Agency; Review Criteria".)

1. Annette Gervais, Kentucky Home Care Association, Lexington, KY, commented that the KHCA requests that the methodology for determining need for additional home health services be reviewed as it does not adequately identify need for additional agencies or distinguish among services. The methodology only considers data that are limited to age, population, and average statewide utilization rates. While instructive for certain purposes, application of a statewide utilization rate to a county is not indicative of "need." Various other factors including, but not limited to, health status, poverty rates, access to other levels of health care, and individual physician practice patterns significantly impact the potential need for additional health care services in a particular area. Need varies significantly across the Commonwealth as do the demographics directly linked to health status and home health utilization. Simply because an applicant satisfies the State Health Plan "need methodology" does not equate to the existence of a true need for an additional service.

2. Garren Colvin, St. Elizabeth Healthcare, stated that St. Elizabeth appreciates the flexibility that has been included in the proposed changes to address changes as a result of new payment systems, like Accountable Care Organizations (ACOs). Hospitals should be provided the opportunity to establish short-term, post-acute transitional care services for their patients, especially those that are at risk for the final outcome and cost of patient care. Complex patients requiring post-acute care are often extremely difficult to place in high quality SNFs within close proximity of their homes.

3. Michael T. Rust, Kentucky Hospital Association, submitted the following comments expressing the organization's support for revising the State Health Plan review criterion for home health care: "The Cabinet proposes to eliminate the criteria exemption for Accountable Care Organizations (ACOs) to establish a home health service notwithstanding the need criteria. KHA has a long standing position supporting hospitals' ability to establish home health services to meet the needs of patients in the county and contiguous county where the hospital is located. The need for home health services is described above and is consistent with the same issues and drivers as the need for post acute transitional care. Additionally, in many areas, existing home health agencies will not accept Medicaid patients. This is creating a significant problem with the expansion of Medicate to serve 470,000 additional adults. This is another reason why hospitals need the ability to offer home health services to properly treat and timely discharge Medicaid patients. KHA recommends the Cabinet modify the language to remove the onerous readmission criteria currently within the SHP for hospitals to establish home health. The Home Health Agency criteria limits expansion of Home Health Agencies by hospitals if they have a high rate of readmissions, essentially depriving those hospitals of a tool needed to reduce readmissions by providing more home health care to their patients. The Plan also creates an unlevel playing field by holding hospitals to different and higher quality standards than existing home health agencies which severely limits hospitals but provides an unfair advantage for certain Home Health Agencies to expand statewide. KHA recommends the following criteria changes under home health:

Review Criteria

1. An application to establish a home health service shall be consistent

with this Plan if there is a projected need for at least two hundred-fifty (250) additional patients needing home health care services in the county for which the application is made as shown in the most recent edition of the Kentucky Annual Home Health Services Report;

2. An application to expand a home health service currently licensed in Kentucky shall be consistent with this[~~the~~] Plan if there is a projected need for at least one hundred twenty-five (125) additional patients needing home health care services in the county for which the application is made as shown in the most recent edition of the Kentucky Annual Home Health Services Report;

3. Notwithstanding criteria [~~Criterion~~] 1 and 2, an application submitted by an existing agency that has met the emergency circumstances provision as outlined in 900 KAR 6:080, Section 2, and has received notice from the Office of Health Policy that an emergency exists shall be consistent with this Plan only if the application is restricted to the limited purpose of alleviating the emergency;

4. Notwithstanding criteria 1 and 2, an application by a licensed Kentucky acute care hospital or critical access hospital proposing to establish a home health service with a service area no larger than the county in which the hospital is located and contiguous counties shall be [~~found~~] consistent with this [~~the~~] Plan if the hospital documents, in the last 12 months, the inability to obtain timely discharge for Medicaid patients or patients with complex care needs which reside in the county of the hospital or a contiguous county and who require home health services[~~if the hospital documents that it is performing "no different than" or "better than" the U.S. National Benchmark for each of the following metrics for which there was a large enough number of patients or cases to report and performing "better than" the U.S. National Benchmark for a minimum of one (1) of the following metrics:~~

a. ~~30-day outcomes for unplanned readmissions for heart attack patients, heart failure patients, pneumonia patients, chronic obstructive pulmonary disease patients, stroke patients, hip/knee surgery patients, and patients hospital-wide as reported by CMS' most recently published Hospital Compare preceding the date the application is filed; and~~

b. ~~30-day death rates for heart attack patients, heart failure patients, pneumonia patients, chronic obstructive pulmonary disease patients, and stroke patients as reported by CMS' most recently published Hospital Compare preceding the date the application is filed; and~~

4. Mark J. Neff, St. Clair Regional Medical Center, Morehead, KY, stated that St. Clair Regional Medical Center requests consideration for additional revisions to the home health criteria to enable hospitals to meet the need of Medicaid patients and those with complex care needs for which there is a lack of access in many areas. Specifically they recommend changes to the Home Health Care Review Criteria. {The exact language of

this proposal is included under sub-comment 3. to this Comment (8) from the Kentucky Hospital Association.)

5. Bud Wethington, TJ Regional Health, Inc., Glasgow, KY, commented: "The Cabinet proposes to eliminate the criteria exemption for Accountable Care Organizations (ACOs) to establish a home health service notwithstanding the need criteria. TJ Regional Health has a long history of providing home health services that meet the needs of patients in our county and contiguous counties in our region. We recommend the Cabinet modify the language to remove the onerous readmission criteria currently within the SHP for hospitals to establish home health. Our biggest area of concern is that the Plan creates an unlevel playing field by holding hospitals to different and higher quality standard than existing home health agencies which provides an unfair advantage for certain Home Health Agencies to expand statewide. Our position is in support of the recommendation made by the Kentucky Hospital Association (KHA)."

6. Annette Gervais, Kentucky Home Care Association, Lexington, KY, commented that KHCA appreciates and strongly supports the deletion of the carve-out for Kentucky-based federally qualified Accountable Care Organizations ("ACO"). The removal of this Review Criterion recognizes the numerous issues that have arisen with its application. There is no support that "common management and control" are required among a home health agency and an ACO to achieve cost savings and quality outcomes. If anything, such a relationship may detrimentally impact referral relationships, which could affect patients' access to home health services. This result will not increase access, improve quality, or reduce costs but rather may negatively impact patients' health, safety, and welfare. Existing home health agencies have successfully formed, and continue to form, partnerships that focus on quality, care coordination and shared savings across the Commonwealth and are currently serving ACO patients.

It is also highly inefficient from a health policy and health planning perspective to permit an ACO affiliated home health agency to apply for a CON in a county that is already adequately served for the prospect of serving a very limited number of Medicare beneficiaries, particularly when an ACO is not a static entity with a known patient base. The ACO affiliated home health agency should bear the burden of establishing need to expand into a new county for all patients, regardless of payor source or the type of home health services to be provided, just like any other home health agency must do. The Cabinet's deletion of the ACO exemption review criterion recognizes all of these important facts. Therefore, the proposed amendment should remain intact.

If the State Health Plan were amended to increase the number of home health agencies, hospices, or private duty nursing agencies without an understanding as to how to address unmet needs, the viability of Kentucky's existing agencies could be compromised as the patient base would be eroded by an influx of additional providers. Kentucky has maintained a stable and economically viable home care industry that delivers quality care to an increasing number of patients. Unlike other states where there has been a proliferation of home care services and agencies, Kentucky has not experienced the same level of CMS and OIG investigations of fraud and abuse.

An examination of the use of telemedicine and other technologies, and increased reimbursement, would also increase access to care. Because home health agencies

have not seen an increase in reimbursement rates in over 20 years, there has been a decline in the number of agencies that accept Medicaid patients. The recent implementation of conflict-free case management for waiver recipients has also required home care companies to address their respective business models.

In other states where CON laws and state health plans have been changed to relax entry, the number of agencies has dramatically increased. Texas and Florida are excellent examples. Several years ago Texas eliminated its CON requirements for home health and today there are over 2,500 Medicare/Medicaid certified home health agencies and that number continues to grow. In Harris County, Texas, close to Houston, there are over 900 home health agencies and they are under intense CMS and OIG scrutiny. Tennessee ultimately reinstated its CON Program due to rampant growth after its repeal. An increase in the number of agencies in these states also increased the cost per Medicare beneficiary, which led to increased federal scrutiny. Historically, when states lift restrictions, they quickly experience dramatic growth in the number of agencies, leading to multiple issues including, but not limited to, CMS and OIG inquiries into fraud and abuse.

7. Richard A. MacMillan, LCH Group, Inc., Lafayette, LA, stated that LHC provides services in twenty-eight (28) states, including Kentucky, where it operates fourteen (14) home health agencies with twenty-seven (27) locations offering Medicare-certified home health services to residents in fifty-five (55) counties. Throughout Kentucky, LHC offers traditional home health services for a wide range of diseases and conditions as well as waiver and supply only services.

Home health care helps patients recover from injury and illness in the comfort of home, reducing avoidable hospital readmissions and keeping healthcare costs down. The home health care industry in Kentucky must maintain its economic viability and stability. LHC strongly supports Kentucky's CON program and the inclusion of review criteria in the State Health Plan, which are necessary to ensure the continued provision of quality care to patients in a cost-effective and efficient manner. However, LHC does not believe that the current Home Health Services Review Criteria achieve the identified goals of the Cabinet's CON Modernization process or the Triple Aim principles. LHC requests that the methodology for determining need for additional home health services be reviewed as it does not adequately identify need for additional agencies or distinguish among payor sources and traditional and waiver home health services.

In other states in which LHC operates where CON laws have been repealed or relaxed, the number of home health agencies has dramatically increased. Florida and Texas are examples. Historically, when CON regulation is relaxed or lifted, states quickly experience dramatic growth in the number of home health agencies; such grown inevitably leads to CMS and OIG fraud investigations. Because of the high rate of fraud cases in other states, CMS implemented a moratorium on new providers in those areas and has extended the moratorium several times. These states' experiences show that elimination of CON results in over capacity, which causes staffing shortages of healthcare professionals. This staffing shortage lowers quality and fragments healthcare delivery networks, and are undesirable results in Kentucky.

Further, LHC strongly supports the deletion of the exemption review criterion for physician-led Kentucky-based federally qualified Accountable Care Organizations (ACO).

There are multiple reasons that support removal of this review criterion. From a health policy and health planning perspective, the ACO exception was based on multiple faulty assumptions. First, there is no support that "common management and control" are required among a home health agency and an ACO to achieve cost savings and quality outcomes. If anything, such a relationship may detrimentally impact referral relationships, which could affect patients' access to home health services. Such a result will not increase access, improve quality, or reduce costs, but may negatively impact patients' health, safety, and welfare. Second, because of the ongoing quarterly retrospective attribution of patients to an ACO by CMS, an ACO is not a static entity with a known patient base. A patient that may be assigned to an ACO one quarter may not be assigned the next, and vice versa.

Existing home health agencies have formed, and continue to form, partnerships that focus on quality, care coordination and shared savings across the Commonwealth and are currently serving ACO patients. LHC agencies have entered into home health joint ventures with hospitals and coordinate provision of post-acute care with hospital partners. In their experience, the ability to coordinate post-acute care is not affected by whether an ACO is involved or not. It is also highly inefficient from a health policy and health planning perspective to permit an ACO affiliated home health agency to apply for a CON in a county that is already adequately served for the prospect of serving a very limited number of Medicare beneficiaries. The ACO affiliated home health agency should bear the burden of establishing need to expand into a new county for all patients, regardless of payor source or the type of home health services to be provided, just like any other home health agency must do.

The Cabinet's deletion of the ACO exemption review criterion recognizes all of these important facts, so the proposed amendment should remain intact. LHC supports the Cabinet's retention of some form of review criteria in the State Health Plan for home health services and deletion of the exemption for physician-led Kentucky-based federally qualified ACOs contained in Review Criteria 6.a. and 6.b. of the State Health Plan.

8. Brian W. Lebanion, Professional Home Health Care Agency, Inc., London, KY, stated that his company supports revisions to the home health review criteria by "removal of criteria #6 (Page 36) in its entirety that unnecessarily allowed a Kentucky-based federally qualitied Accountable Care Organization (ACO), or the Next General ACO Model or by a Kentucky affiliated home health services in a county in which it is not currently authorized to operate but in which such ACO does operate" and "removal of criteria #7 (Page 37) in its entirety that would require participation in the Cabinet's National Background Check Program." He also commented that "there is no documentation that supports the need for Accountable Care Organizations (ACO) to be able to establish a home health service solely based on the type of entity that are" and "no evidence that a home health agency established by an ACO provides any different or better care" than other home health agencies. Additionally, "there is no rational to require home health agencies to utilize the Cabinet's National Background Check Program and it is cost-prohibitive" and "contains overly burdensome requirements that will adversely affect a home health agencies ability to hire, train, and retain qualified staff."

The SHP's calculation has been proven to adequately predict the need of home health in each Kentucky county and does not discriminate in favor of a particular business

model. The latest published home health need calculations indicate that there is not a need for increased leniency of the CON process for home health services. Allowing special interest groups, such as ACOs, to bypass this important component will result in duplication and proliferation of unnecessary services.

Kentucky should learn from other states' experiences, including Florida, Illinois, Michigan, and Texas. Additionally, Tennessee had negative results during the three (3) year period it did not have a CON process in place for home health. The CON process was home health for reinstated because the number of home health agencies dramatically increased; rural areas had concerns about access to home health services; over ninety (90) percent of the home health business models served Medicare patients, which did not benefit the state's Medicaid and indigent populations; the state's licensure oversight responsibilities doubled, increasing state budget requirements for regulatory staff; and aggressive mass marketing negatively impacted consumers and physicians.

The proposed changes will strengthen the CON process and healthcare delivery systems by 1) reducing fragmentation and improving integration of providers; 2) reducing the unnecessary proliferation of duplicative and unnecessary services; 3) improving quality of care by utilizing limited recourses wisely; and 4) strengthening the efficacy of the CON process. These changes are in accordance with valid health planning principles and will ensure the limited resources of the Commonwealth remain tightly oversighted and protected.

9. Patricia T. Mason, Baptist Health, Louisville, KY, commented that Baptist Health requests that criteria for development and expansion of home care services be amended to re-instate the exemption for Accountable Care Organizations (ACOs). It is important that hospitals or health systems who own home care agencies be able to expand those services into counties and contiguous counties in which their hospitals are located. This is particularly true in situations where hospitals are also participants or owners of ACOs. The same flexibility exhibited in changes to the State Health Plan regarding post-acute rehabilitation services should apply to home care as the same issues and drivers apply.

Baptist Health requests that the ACO exemption for establishment of home care services be re-instated, as it allows for greater control of costs and continuity of care for patients from the acute care setting to the home setting. Important points to consider regarding ACO exemption are as follows:

- An ACO is a group of healthcare providers responsible for managing total costs and total quality of healthcare for a population of patients.
- ACOs differ from the traditional model of care where a provider treats a single patient, one symptom at a time. Rather, under the ACO model the provider is responsible for an entire population of patients and is accountable for patients regardless of whether a patient is currently receiving treatment.
- CMS initiated ACOs to align quality of care, continuity of care, and cost savings through a new coordinated care regime.
- ACOs represent a patient centered model that integrates providers across the continuum of care to appropriately manage the overall treatment of a patient. The burden is placed on providers to control costs and manage care.
- Under ACOs, providers are incentivized to efficiently utilize resources because they are disincented from providing volume. Rather, they must manage overall

quality and overall costs.

- Access to data and management of the data are important components of the practice transformation envisioned by the ACO movement. Providers need access to data in order to efficiently manage their patient population, and the ACO is responsible for evaluating the information and making it meaningful to the providers. This is most easily accomplished when the patient is on a single electronic medical record ("EMR") and the EMR is designed to capture all information about the patient's care in a single place where caregivers have full access. Such a structure also helps to prevent medication or other errors.
- ACOs that are part of a health system that also offers acute care, home health services and provides an integrated EMR are in a unique situation to benefit patients, produce good patient outcomes, and reduce overall costs of care.

In order to accomplish these goals, support is needed from the Cabinet to allow for care delivery models that create an integrated care model, such as ACOs, specifically as it relates to provision of home health care. Therefore, Baptist Health requests consideration of re-instating the ACO exemption.

Baptist Health is aware of KHA comments related to home health criteria and agrees with the recommendation that language be modified in the home care criteria to remove the readmission criteria currently within the State Health Plan. These criteria have created an unlevel playing field by holding hospitals to different and higher quality standards than existing home care agencies. It has contributed to the status quo and has limited the ability of hospitals to expand services while giving other agencies that opportunity. Baptist Health also supports the KHA comments that would give Kentucky hospitals who are seeking to establish home care agencies the opportunity to expand if there have been placement issues for Medicaid patients or patients with complex care needs.

10. Ron Evans, CHI Health at Home, Milford, OH, submitted comments requesting that the "proposed omission of the 'ACO exception' be included in the SHP Review Criteria for Home Health Services; the proposed omission of the ACO exception will undermine the continuity of care and cost effectiveness of ACOs." Further, Mr. Evans stated: "KentuckyOne Health Partners, LLC (KHP) is the Kentucky-based ACO extension of Catholic Health Initiatives" which is a "clinically integrated network, and the only organization in Kentucky that meets" certain CMS criteria for ACOs and KHP manages "over 115,000 lives, including 28,000 lives in the Medicare ACO." Mr. Evans commented that removal of the ACO exception from the home health review criteria "will impair the effective function of ACOs, result in higher costs for Medicare beneficiaries and providers, and impair continuity of care for patients."

He emphasized the goals of ACO in coordinating a continuum of care and offered the following language to be added to the State Health Plan review criteria for home health:

> 6. Notwithstanding criteria 1 and 2, an application to provide home health services shall be consistent with this Plan in the application is submitted by:
>
> a. An entity or entities that is a member or owned by a member of a Kentucky-based Accountable Care Organization ("ACO") or owned by a

member under the Medicare Shared Savings Program or the Next Generation ACO Model, proposing to serve counties where its attributed patients reside; or

b. A licensed Kentucky home health agency which shares common management and control with an entity that provides substantial health management services to a Kentucky-based federally qualified Accountable Care Organization ("ACO") under the Medicare Shared Savings Program or the Next Generation ACO Model, to provide home health services within counties where attributed patients of the ACO reside;

Mr. Evans commented: "From a policy standpoint, we feel that this proposed exception allowed home health providers, who are members of an ACO to provide high quality, coordinated and cost effective care to Medicare participants, as well as the ability to meet the federal mandates for an ACO to provide comprehensive services to its beneficiaries."

(b) Response: The Cabinet appreciates the comments regarding Home Health Care. The revised State Health Plan filed July 13, 2017, preserved the ability of hospitals to establish home health services if the hospital documented that it was performing "no different than" or "better than" the U.S. National Benchmark for specified benchmarks. See III. Long-Term Care; B. Home Health Agency; Review Criteria, #4. However, the benchmarks measured by criterion #4.a. and b. do not accomplish the intended purpose in practice. Hospitals have a duty and responsibility for safe and effective discharge planning. In circumstances where there are not any available settings with existing home health providers, the hospital is still responsible for that patient and is held accountable for re-admissions. Thus, a hospital should be allowed to follow a patient home if the patient cannot be placed with an existing home health provider. Review Criterion #4 will be amended. However, the Cabinet is modifying the criterion proposed by the Kentucky Hospital Association to remove the reference to "Medicaid patients or patients with complex care needs". The hospital's duty to a patient is not dependent on whether the patient receives Medicaid or have complex care needs. The revisions to Criterion #4 will read as follows:

4. Notwithstanding criteria 1 and 2, an application by a licensed Kentucky acute care hospital or critical access hospital proposing to establish a home health service with a service area no larger than the county in which the hospital is located and contiguous counties shall be [~~found~~] consistent with this [~~the~~] Plan if the hospital documents**, in the last twelve (12) months, the inability to obtain timely discharge for patients who reside in the county of the hospital or a contiguous county and who require home health services at the time of discharge**[~~that it is performing "no different than" or "better than" the U.S. National Benchmark for each of the following metrics for which there was a large enough number of patients or cases to report and performing "better than" the U.S. National Benchmark for a minimum of one (1) of the following metrics:~~

~~a. 30-day outcomes for unplanned readmissions for heart attack patients, heart failure patients, pneumonia patients,~~

~~**chronic obstructive pulmonary disease patients, stroke patients, hip/knee surgery patients, and patients hospital-wide as reported by CMS' most recently published Hospital Compare preceding the date the application is filed; and**~~

~~**b. 30-day death rates for heart attack patients, heart failure patients, pneumonia patients, chronic obstructive pulmonary disease patients, and stroke patients as reported by CMS' most recently published Hospital Compare preceding the date the application is filed**~~]; and

Regarding Review Criterion #6, it has not been demonstrated that ACOs are more qualified than existing non-ACO home health agencies in providing home health. The Cabinet has decided not to re-insert the deleted criterion #6. The Cabinet will continue its ongoing review of the State Health Plan, including the methodology for determining need for additional home health services.

(9) Subject: Intermediate Care Facilities for Individuals with an Intellectual Disability

(a) Comment: Comments regarding the changes in the State Health Plan regarding Intermediate Care Facilities for Individuals with an Intellectual Disability were received from Protection & Advocacy. (This comment relates to "III. Long-Term Care; E. Intermediate Care Facility for Individuals with an Intellectual Disability; Review Criteria".)

Heidi Schissler Lanham, Protection & Advocacy, Frankfort, KY, stated that the criteria of the State Health Plan regarding intermediate care facilities for individuals with an intellectual disability should be changed to prohibit the transfer of public ICF/IID beds to private entities potentially running afoul of the spirit of the Cabinet's agreement in *Michelle P. et al v. Birdwhistell, et al.,* United States District Court, Eastern District of Kentucky, Frankfort Division, Civil Action #02-23-JMH.

The new language would read: "An[~~No~~] application for a new ICF/IID shall not be consistent with this Plan unless it is limited to a transfer of ICF/IID beds from an existing **private** ICF/IID facility to the proposed **private** ICF/IID facility. An[~~No~~] application to increase the number of beds at an existing **private** ICF/IID facility shall not be consistent with this[~~the~~] Plan unless the increase in beds is accomplished by transferring beds from an existing **private** ICF/IID facility."

The Cabinet should consider de-certifying or de-licensing some of the over 400 public ICF/IID beds that are not and will not ever be in use.

(b) Response: The Cabinet has considered this comment and will not amend the ICF/IID review criteria at this time. The existing review criteria provides the Cabinet with flexibility necessary to transfer public ICF/IID beds to private ICF/IID facilities without increasing the total number of ICF/IID beds available statewide.

(10) Subject: Private Duty Nursing

(a) Comment: Comments regarding the changes in the State Health Plan regarding Private Duty Nursing were received from Professional Case Management. (This comment

relates to “V. Miscellaneous Services; D. Private Duty Nursing Services; Definition”.)

Laura B. Alms, Professional Case Management, Denver, CO, commented regarding “Private Duty Nursing Services”, which is under V. Miscellaneous Services, Part D. The Cabinet amended the definition to read as follows:

> A “Private Duty Nursing Service”, licensed pursuant to 902 KAR 20:370, is a non-Medicare certified [~~an~~] entity that provides licensed nursing care to a patient [~~patients~~] in his or her home [~~for a continuous block of time, in increments of at least four hours,~~] in which the private duty nursing service supervises [~~nursing~~] care provided by agency personnel.

The unchanged definition in 902 KAR 20:370, Section 1(5) provides as follows:

> "Private duty nursing agency" means an entity in the business of providing licensed nursing care to a patient in his or her home for a continuous block of time, in increments of at least four (4) hours, in which the private duty nursing agency supervises nursing care provided by agency personnel. It shall not include a registered nurse providing nursing services as an independent practitioner.

In light of the reference in the proposed State Health Plan to the administrative regulation governing Private Duty Nursing Agencies, PCM requested that the term “Private duty nursing service” be change to “private duty nursing agency”.

Further, to provide clarity that both the skill level of nursing requirement and the four (4) hour increment requirement remain intact notwithstanding the proposed changes, and also to make the terms of the definitions of “home health agency” and “private duty nursing agency” parallel, PCM suggests that the proposed changes to the definition of “Private Duty Nursing Agency” be revised to include a second reference to 907 KAR 20:370 as follows (in bold):

> A “Private Duty Nursing **Agency[~~Service~~]**”, licensed pursuant to 902 KAR 20:370, is a non-Medicare certified [~~an~~] entity that provides licensed nursing care to a patient [~~patients~~] in his or her home [~~for a continuous block of time, in increments of at least four hours,~~] in which the **agency[~~private duty nursing service~~]** supervises [~~nursing~~] care provided by agency personnel **in accordance with the requirements of 902 KAR 20:370**.

Unlike a home health agency, entities licensed as a private duty nursing agency may provide very limited services. By adding the second reference to 902 KAR 20:370, the limited services of a private duty nursing agency are emphasized.

(b) Response: The Cabinet appreciates the comments regarding private duty nursing. The changes made in the July 2017 proposed State Health Plan to the definition of “Private Duty Nursing Service” eliminated redundancy but did not substantively change the criteria. However, after reviewing the comments from Professional Case Management, the Cabinet has decided to amend the definition as requested, changing the defined term from “service” to “agency” and adding a second cross-reference to 902 KAR 20:370. Additional conforming amendments were also made. A separate definition of “private duty nursing service” was established (and the word “Definition” was changed to “Definitions”). References to “private duty nursing service” in the Table of Contents and as a Section Heading were changed to “Private Duty Nursing”. A reference in the Review Criteria was also changed from “service” to “agency”.

(11) Subject: Annual Reports

(a) Comment: Comments regarding Annual Reports required by the State Health Plan were received from the Kentucky Home Care Association.

Annette Gervais, Kentucky Home Care Association, Lexington, KY, commented that another issue that continues to arise is whether a patient population is underserved, such as those participating in a waiver program or with a payor source other than Medicare. It would be helpful if this data were captured in the annual reports so specific needs could be identified and addressed.

(b) Response: The Cabinet appreciates the comments regarding Annual Reports. However, the annual reporting requirements are established in a separate administrative regulation, 900 KAR 6:125.

(12) Subject: Support of Kentucky Hospital Association Comments

(a) Comment: Comments in support of the comments submitted by the Kentucky Hospital Association were received from several organizations and providers. Their letters of support relate to the Kentucky Hospital Association comments summarized in this Statement of Consideration as Comments (1)(a)1., General Support for Certificate of Need; (3)(a)1., Neonatal Care Beds; (4)(a)1., Psychiatric Residential Treatment Facilities; (6)(a)4., Post-Acute Rehabilitation Beds (Comments in Support); and (8)(a)3., Home Health Care.

Tommy Haggard, Bluegrass Community Hospital, Versailles, KY; Kevin Halter, Our Lady of Bellefonte Hospital and Bon Secours Kentucky Health System, Russell, KY; Garren Colvin, St. Elizabeth Healthcare; Michael Slusher, Middlesboro Appalachian Regional Healthcare; Ina Glass, Ephraim McDowell Fort Logan Hospital and Ephraim McDowell Health; Harry M. Hays, Carroll County Memorial Hospital; Matt Smith, Bourbon Community Hospital, Paris, KY; Robert Parker, Clark Regional Medical Center, Winchester, KY; Wade R. Stone, Med Center Health, Bowling Green, KY; David Anderson, Jackson Purchase Medical Center, Mayfield, KY; Charles Lovell, Jr., Barbourville Appalachian Regional Healthcare, Barbourville, KY; Michael Yungmann, Lourdes Hospital and Mercy Health, Paducah, KY; Brian Springate, Fleming County Hospital, Flemingsburg, KY; Tim Trottier, Spring View Hospital, Lebanon, KY; Mark Neff, St. Claire Regional Medical Center; Connie D. Smith, The Medical Center; Bud Wethington, TJ Regional Health, Inc., Glasgow, KY; and Russ Ranallo, Owensboro Health, Owensboro, KY; stated that they support the Kentucky Hospital Association's comments regarding the proposed changes to the State Health Plan.

(b) Response: The Cabinet appreciates the comments regarding these organizations and providers' support for the Kentucky Hospital Association's comments. For specific responses regarding each of the comments submitted by the Kentucky Hospital Association, please see the Responses to Comments (1)(a)1., General Support for Certificate of Need; Comment (3)(a)1., Neonatal Care Beds; Comment (4)(a)1., Psychiatric Residential Treatment Facilities; Comment (6)(a)4., Post-Acute Rehabilitation

Beds (Comments in Support); and Comment (8)(a)3., Home Health Care.

(13) Subject: Drafting Changes Needed throughout the State Health Plan

(a) Comment: Donna Little, Cabinet for Health and Family Services, commented that a number of drafting corrections were needed throughout the State Health Plan for grammatical correctness, to use the same forms of expression and numbering format throughout the Plan, and to correct other typographical errors. These items are technical in nature and do not involve substantive changes.

(b) Response: The Cabinet appreciates the thorough review of the State Health Plan and agrees to the drafting, numbering, and other technical, non-substantive changes that are needed throughout the Plan. The specific changes are listed separately in the last section of this Statement of Consideration.

V. Summary of Statement of Consideration and Action Taken by Promulgating Administrative Body

The public hearing on this administrative regulation was held, and written comments were received. The Cabinet for Health and Family Services, Office of Health Policy, has responded to the comments and will be amending the administrative regulation as follows:

Page 1
Section 2(1)
Line 19

After "Plan',", insert "<u>October</u>".
Delete "July".

Substantive Changes to the Material Incorporated by Reference

(In response to the comments received outside CHFS)

(Page numbers relate to the "clean" copy of the State Health Plan filed July 13, 2017.)

- Page 1, Title Page, to change the edition date from "July" to "October" 2017 in two (2) places;
- Page ii., Table of Contents, V. Miscellaneous Services, Topic D., the word "service" was deleted, leaving the phrase "private duty nursing";

- Page 13, I. Acute Care; D. Special Care Neonatal Beds; Review Criteria for Level II special care neonatal beds, Criterion 10, by changing "800" to "700". This criterion will read as follows"

  10. Notwithstanding criteria 1 and 3, if the most recently published inventory and utilization data indicates that the applicant had **<u>700</u>[~~800~~]** or more annual births, an application to establish a Level II program by designating up to eight (8) acute care beds as Level II special care neonatal beds shall be consistent with this Plan; and
- Page 31, III. Long-Term Care; A. Nursing Facility Beds; Need Assessment for Nursing

Facility Beds, explanation for "C =", the last sentence was amended to read as follows:

Nursing **facility beds approved pursuant to the Post-Acute Transitional Care Pilot Program[~~home beds for the provision of post-acute rehabilitation services~~]** shall not be included in the calculation.

- Page 32, III. Long-Term Care; A. Nursing Facility Beds; Review Criterion #5, will read as follows:

5. Kentucky ranks forty-ninth (49th) out of the fifty (50) states in hospital readmission rates, which creates a financial burden for hospitals located in the Commonwealth of Kentucky. The Cabinet hereby establishes a pilot program pursuant to this criterion, to be known as the Post-Acute Transitional Care Pilot Program, for the purpose of addressing Kentucky's high hospital readmission rates. Notwithstanding criteria 1, 2, 3, and 4, no more than a total of four (4) applications, with up to two (2) located in a rural Core Based Statistical Area (CBSA) and up to two (2) located in an urban CBSA, establishing nursing facility beds in a freestanding facility or as part of an existing facility pursuant to the Post-Acute Transitional Care Pilot Program shall be consistent with this Plan if the applicant:
   a. Satisfies all other requirements of certificate of need, including the formal review; and
   b. Demonstrates the following:
      i. The annual average length of stay for the proposed nursing facility beds shall not exceed twenty-one (21) days;
      ii. Readmission rates for hospitals discharging patients to the proposed nursing facility beds will decrease;
      iii. Seventy-five (75) percent or more of patients discharged from the proposed nursing facility beds will transition to a home or community based setting; and
      iv. The applicant agrees to submit an annual report on the average length of stay within their nursing facility beds, hospital readmission rates, and discharge settings to the Cabinet for Health and Family Services[~~Notwithstanding criteria 1, 2, 3, and 4, an application to establish nursing home beds for the provision of post-acute rehabilitation services shall be consistent with this Plan if the proposed annual average length of stay of the nursing home beds does not exceed twenty-one (21) days~~].

- (Note: Due to these changes, the page numbers for this part of the State Health Plan have changed. Corresponding changes were also made on Page ii, the Table of Contents. The page number references in this section of the SOC, however, continue to reference the page numbers in the clean version filed July 13, 2017.)

- Page 34, III. Long-Term Care; B. Home Health Agency; Review Criteria, #4, will read as follows:

4. Notwithstanding criteria 1 and 2, an application by a licensed Kentucky acute care hospital or critical access hospital proposing to establish a home health service with a service area no larger than

the county in which the hospital is located and contiguous counties shall be [~~found~~] consistent with this [~~the~~] Plan if the hospital documents**, in the last twelve (12) months, the inability to obtain timely discharge for patients who reside in the county of the hospital or a contiguous county and who require home health services at the time of discharge[~~that it is performing "no different than" or "better than" the U.S. National Benchmark for each of the following metrics for which there was a large enough number of patients or cases to report and performing "better than" the U.S. National Benchmark for a minimum of one (1) of the following metrics:~~**

~~a. 30-day outcomes for unplanned readmissions for heart attack patients, heart failure patients, pneumonia patients, chronic obstructive pulmonary disease patients, stroke patients, hip/knee surgery patients, and patients hospital-wide as reported by CMS' most recently published Hospital Compare preceding the date the application is filed; and~~

~~b. 30-day death rates for heart attack patients, heart failure patients, pneumonia patients, chronic obstructive pulmonary disease patients, and stroke patients as reported by CMS' most recently published Hospital Compare preceding the date the application is filed~~]; and

- Page 59, V. Miscellaneous Services; D. Private Duty Nursing Services
  - In the subtitle, the word "service" was deleted, leaving the phrase "private duty nursing";
  - The definition section was changed as follows:

    Definitions[~~Definition~~]

    A "Private Duty Nursing **Agency[~~Service~~]**", licensed pursuant to 902 KAR 20:370, is a non-Medicare certified [~~an~~] entity that provides licensed nursing care to a patient [~~patients~~] in his or her home [~~for a continuous block of time, in increments of at least four hours,~~] in which the **agency[~~private duty nursing service~~]** supervises [~~nursing~~] care provided by agency personnel **in accordance with the requirements of 902 KAR 20:370**.

    "Private duty nursing service" means a service provided by a private duty nursing agency.
  - Under "Review Criteria", the first reference to "service" was changed to "agency"

Non-Substantive Changes to the Material Incorporated by Reference

(In response to the in-house review of the State Health Plan within CHFS and the subject of Comment (13)'s Summary and Response)

- Page 1, Definition of "Acute Care Hospital", in two (2) places in this paragraph, after "licensed by the", the phrase "Cabinet for Health and Family Services," was inserted and "Kentucky" was deleted;
    - After "Office of Inspector General", ", Division of Health Care" was deleted;
    - In that same definition, in the last sentence, after "the term", quotation marks were placed around "acute care hospital";
- Page 1, Definition of "Specialty Hospital", in the last line, after "one", "(1)" was inserted;
- Page 2, Review Criterion 1, after "one", "(1)" was inserted;
- Page 2, Review Criterion 1.c., after "one", "(1)" was inserted;
- Page 3, Review Criterion 2.d., after "d.", "Identification of" was inserted and "The applicant shall identify" was deleted;
- Page 3, Review Criterion 2.e., after "e.", "That" was inserted; "The" was lower-cased"; after "applicant", "shall demonstrate that it" was deleted;
- Page 7, Definition, after "one", "(1)" was inserted;
- Page 8, Review Criterion 4., after "approve more", "comprehensive physical" was inserted;
- Page 8, Review Criterion 5., "one hundred (100)" was changed to "100";
    - In that same criterion, in the dirty version only, the "s" in the newly inserted word "this" was underlined;
- Page 8, Review Criterion 6.a., "80%" was changed to "eighty (80) percent";
- Page 10, Review Criterion 1., formula, after "in the ADD", a space was inserted before the equal sign;
- Page 10, Review Criterion 6., after "special care neonatal", "care" was deleted;
- Page 11, Review Criterion 7., after "special care neonatal", "care" was deleted;
- Page 11, Review Criterion 7.a., after "one", "(1)" was inserted;
- Page 12, Review Criterion 7.a.iv.(c), after "two", "(2)" was inserted;
- Page 12, Review Criterion 7.a.iv.(d), after "met by the", "referral" was inserted and "referring" was deleted;
- Page 12, Review Criterion 7.a.iv.(e), the opening and closing brackets ("[") and ("]") were changed to opening and closing braces ("{") and ("}");
- Page 12, Review Criterion 7.a.v., after "at a minimum", a comma was inserted;
- Page 13, Review Criterion 11, in the clean version only, "which" was changed to "that". (This change was already indicated in the dirty version but was overlooked in the clean version filed July 13, 2017);
- Page 14, Review Criterion 3., and 3.a., after "special care neonatal", "care" was deleted;
- Page 14, Review Criterion 3.j., after "procedures performed", "in" was changed to "on";
- Page 15, Review Criterion 3.m., after "one", "(1)" was inserted;
- Page 16, Review Criterion 2., after "special care neonatal", "care" was deleted;
- Page 16, Review Criterion 6., "28" was changed to "twenty-eight (28)" in the clean version (this change was already indicated in the dirty version but was overlooked in

the clean version filed July 13, 2017);

- Page 17, Review Criterion 6.c.iii., after “two”, “(2)” was inserted;
- Page 17, Review Criterion 6.c.iv., after “met by the”, “referral” was inserted and “referring” was deleted;
- Page 17, Review Criterion 7., after “with”, “a” was inserted and “facilities” was changed to “facility”;
- Pages 18 and 19 – the non-hyphenated phrase “open heart” was changed to the hyphenated phrase “open-heart” to have consistency with the hyphen usage and to match the style recommended by the John Hopkins Medicine Style, 2013, and The New York Times Manual of Style and Usage, 5th Edition, 2015;
    - This change was also made on Page ii, Table of Contents, for I., E., and Page 43, Review Criterion 2.f.;
- Page 20, Definition, after “tissue from one”, “(1)” was inserted;
- Page 22, Review Criterion 4., after “Table 1”, “of Criterion 2” was inserted and “above” was deleted;
- Page 22, Review Criterion 6.a., in the clean version, after “1, 4, and 5”, delete “above” (this change was already made in the July 13, 2017 dirty version);
- Page 23, Review Criterion 8., after “functional capacity”, a comma was inserted;
- Page 24, Review Criterion 2., after “thirty”, “(30)” was inserted;
- Page 24, Review Criterion 4.e., after “for the provisions”, “for” was changed to “of”;
- Page 27, Review Criterion 2.e., after “projected number of”, “DCBS” was changed to “Department for Community Based Services (DCBS)”;
- Page 27, Review Criterion 4., after “describe how”, “the Department for Community Based Services (DCBS)” was changed to “DCBS”;
    - Also “21” was changed to “twenty-one (21)”;
- Page 28, Review Criterion 9.e., after “one”, “(1)” was inserted;
- Page 29, Review Criterion 4.g., after “g,”, “Document” was inserted and “Clear” was lower-cased;
- Page 29, Review Criterion 10., “Applicants” was changed to “The Applicant”;
- Page 30, Review Criterion 13., “Applications” was changed to “An application”;
- Page 30, Review Criterion 13.e., after “one”, “(1)” was inserted;
- Page 30, Review Criterion 14., after “In approving”, “a” was inserted and “applications” was changed to “application”;
- Page 31, In the explanation for “C =”, after “non-state owned”, the underline was removed from the space before “and non-CCRC” in the clean version;
- Page 32, Review Criterion 4., in the clean version, after “in a county that is not”, the word “adjoining” was changed to “contiguous” to match the word used in the dirty version filed July 13, 2017, and for consistency;
- Page 33, first paragraph under “Summary of Need Criteria”, in two (2) places, after “two”, “(2)” was inserted;
- Page 34, Review Criterion 1., “two hundred-fifty (250)” was changed to “250”;
- Page 34, Review Criterion 2., “one hundred twenty-five (125)” was changed to “125”;
- Page 34, Review Criterion 3., after “by an existing”, “home health” was inserted before “agency”;
- Page 35, Subtitle – After “Hospice”, “Service” was changed to “Services”

    - This change was also made on Page ii., the Table of Contents;
- Page 37, Review Criterion 1.b., a hyphen was inserted in “thirty-six”;
- Page 37, Review Criterion 1.c., after “application”, “for hospice services”;
- Page 37, Review Criterion 2., after “one”, “(1)” was inserted;
- Page 40, Definition, First Paragraph, after “ICD-10”, the underlining was removed from the space before “Procedure” in the clean version only;
- Page 41, Review Criterion 1.a., after “licensed by the”, the phrase “Cabinet for Health and Family Services,” was inserted and “Kentucky” was deleted;
    - After “Office of Inspector General”, “, Division of Health Care” was deleted;
- Page 41, Review Criterion 1.b., in the clean version, after “shall have performed at”, “least” was inserted. (The word is present in the dirty version filed July 13, 2017 but was not included in that clean version.)
- Page 41, Review Criterion 1.c.ii., after “from the total for each”, “fixed-site laboratory” was inserted;
- Page 41, Review Criterion 1.c. (the second occurrence of “c.”) – this item was renumbered as “d.” because there was already a “c.”;
- Page 43, Review Criterion 2.i., after “shall maintain”, “a” was changed to “an”;
- Page 44, Review Criterion 2.n., “50” was changed to “fifty (50)”;
- Page 44, Review Criterion 3.a., in two (2) places “two hundred and fifty (250)” was changed to “250” and once, “five hundred and fifty (550)” was changed to “550”;
- Page 45, Review Criterion 8.a., after “two”, “(2)” was inserted;
- Page 46, Definition of “Qualified Academic Medical Center”, paragraph (a) – the ending punctuation was changed from a comma to a semi-colon for consistency;
- Page 48, Review Criterion 6.b., “12” was changed to “twelve (12)”;
- Page 49, Definition of “Megavoltage Radiation Equipment”, after “two”, “(2)” was inserted;
- Page 50, Definition of “Positron Emission Tomography”, after “Tomography’”, the phrase “or “PET”” was inserted and “(PET)” was deleted in the clean version only. This change was already indicated in the dirty version filed July 13, 2017;
- Page 50, Definition of “PET Program”, after “one”, “(1)” was inserted;
- Page 50, Definition of “mobile PET Scanner”, after “two”, “(2)” was inserted;
- Page 51, Review Criterion 4., in the clean version, after “to exceed”, “one (1) per” was inserted (the phrase is present in the dirty version filed July 13, 2017 but was not included in that clean version);
- Page 53, Definition of “Ambulance Service”, sentence regarding “Class II ground ambulance services”, after “providing scheduled ambulance transportation”, the comma should be deleted in the dirty version. It was already deleted in the clean version filed July 13, 2017;
- Page 54, Review Criterion 3., a hyphen was inserted in “inter-facility”;
- Page 55, Definition, “Surgery” was changed to “Surgical”;
    - After “scheduled procedures”, “which” was changed to “that”;
- Page 55, Review Criterion 3., after “the center;”, “and” was deleted;
- Page 56, Review Criterion 5.c., after “2016”, a comma was inserted;
- Page 57, Review Criterion 7., after “establish an “ASC”, in the clean version, “which” was changed to “that”. (That change was already indicated in the dirty version filed

July 13, 2017 but the change was overlooked in the clean version.);

- Page 59, Review Criterion 2., after “from the”, “Cabinet for Health and Family Services,” was inserted;
- Page 59, Review Criterion 3., after “home health agencies or private duty nursing”, “agencies” was inserted and the phrase “service providers” was deleted;
- Page 60, Review Criterion 4., after “consistent with this”, the underlining was removed from the space before “Plan” and before “according”, the underlining was removed from the space. (These two changes were only needed in the clean version.)
    - Also, after “home health agencies or private duty nursing”, “agencies” was inserted and the phrase “service providers” was deleted.